



Evaluation Report on the South Asian Infant Nutrition Worker Project

Client: NRF, SAHLP, NHLO CC's

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Executive Summary

The purpose of this report is to set out the findings of the evaluation of the South Asian Weaning Project. The question being addressed by this evaluation is whether a South Asian Infant Nutrition Worker (SAINW) can bring about changes in the weaning patterns of families with a South Asian origin that statutory agencies find difficult to reach.

Rationale and Background

The extensive literature relating to the inadequacy of the weaning diet in some British Pakistani and Bangladeshi families suggests that weaning advice and support offered by routine Health Visitor contact to families is often ineffective. The Birkby/Fartown area of Huddersfield has a high proportion of South Asian families and concerns have been highlighted as to health effects of incorrect weaning. This has presented enormous challenges to Health Visitors in meeting the needs of this population. In 2004 a bid for further funding of the public health campaign and the running of a South Asian Weaning Project was successfully bid for from the South Asian Healthy Living Partnership (SAHLP), which is a Healthy Living centre funded, by the Big Lottery.

Scope of the Evaluation

This evaluation is being undertaken to provide information to the Public Health Directorate within the two Huddersfield Primary Care Trusts as to whether the project, initially funded for two years, should be mainstreamed once funding from SAHLP has ceased.

The evaluation is about assessing whether this particular type of approach of delivering weaning messages either in the clients own home or as a group has added value to those families and health care professionals within the Deighton and East Fartown Sure Start Area of Huddersfield

The question being addressed by this evaluation is whether a SAINW can bring about changes in the weaning patterns of families with a South Asian origin that statutory agencies find difficult to reach. The objectives have been determined from the evaluation question in relation to the groups of people whose behaviour the project is aiming to have an impact on. The groups being: families/mothers, SAINW and Health Visiting Teams.

Methodology

The methodology used consisted of both quantitative and qualitative techniques. Triangulation of data was undertaken when ever possible.

Findings

Objectives of Project

The objectives that were identified by the SAINW reflected those in the original proposal, as did the Health Visiting Teams. The Health Visitor teams addressed the point of whether these objectives had been met, they felt that the delivery had been culturally sensitive and the target number of families had been seen also that their workload had been impacted upon.

Value of Project

The value of the project/role was viewed positively benefiting both the families and the service with improvements in communication, quality, information and efficiency. The monitoring data showed that the referral reasons reflected the original aims of the project.

Induction, Training and Support

The general feeling was that this had worked well and to some extent this could be attributed to the individual. There were differing views on experience or background needed for this role. The support and training was viewed as comprehensive, although it was recommended that an element around children's behaviour would have been beneficial.

Referrals

The Health Visitors completed an initial referral with levels of priority, reasons for referral (numbered), and additional notes. This form developed over time. A discussion between the Health Visitor and the SAINW accompanied each referral. The SAINW completed contact and outcome sheets, which were available for monitoring. There was duplication of information and an increase in paperwork some of which the staff viewed as necessary.

Barriers, Challenges and Concerns

Financial, time, resources and support issues were faced in the initial stages of the project. Lack of appropriate resources, good quality information in community languages, office space and interpreter information was an ongoing concern. The challenge of increasing group attendances needs addressing further. The issue of managing behaviour change within the extended families was a concern to the mothers and health teams.

Suggested changes to the project (by parents and SAINW)

Key aspects that were already part of the project i.e. personal home visiting contact and skills i.e. life experience were endorsed by the mothers. They also suggested targeting groups and making use of Asian radio to reach members of the community in their own homes. The SAINW identified the main change needed was around the availability of supporting information/leaflets in appropriate languages

Outcomes and Changes

The monitoring information showed out of the 45 referrals there are 31 positive outcomes recorded. The mothers talked about positive changes around confidence, knowledge and application due to the intervention.

The health teams felt the objectives of the project were met, viewing their changing workload around nutrition issues. They felt the continuity of the project necessary to bring about change in the long term, citing the need to constantly reinforce information and deliver culturally sensitive interventions.

Conclusions

Initial findings of the evaluation indicate that this approach has been successful in addressing the original aims of the project. For example, the positive outcomes of the referral to the SAINW for families with a lack of a balanced diet are linked to a lower risk of anaemia, dental health, and obesity. Findings also indicate that the referral reasons reflect local health concerns.

The project was effective in providing a culturally sensitive service with improved quality, efficiency, and capacity for intensive interventions.

Work needs to be done to investigate cost effectiveness, however, the reduction in the use of interpreters along with telephone support replacing some home visits are potential cost savings which may partly offset the cost of the SAINW. In the long term this may lead to savings in diet related illness, which require more expensive treatments, for example referrals to paediatricians, dieticians and treatment of dental decay.

Monitoring information based on the perception of the SAINW and Health teams indicate that the original objectives were met. They valued the project as it relieved the nutritional workload and was culturally sensitive, bringing an added dimension to the Health team. Although there were small numbers of parents that took part in the focus groups, they were clear about the positive benefits of the project.

The common barrier identified by the Health teams and parents, was the influence of extended families and the recognition of this when considering changes in behaviour. The SAINW indicated lack of appropriate information and low group attendances as ongoing barriers.

During the evaluation home visits were seen as more effective, reasons for this include an identified need and the consent from parents to be referred to the project. Potential group attendees were targeted by age of child rather than any identified problems, therefore the necessity or appropriateness may have been questioned. The mothers, when describing how they would deliver this intervention to their own community, confirmed the value of receiving information and guidance in the home.

Recommendations

To continue to consult with service users and providers when planning to develop activities and services.

Continue to deliver the information and support in an effective and culturally sensitive format that the target audience can understand.

Sufficient support and resources need to be in place for the SAINW including training around children's behaviour during the SAINW's induction period, and having information in community languages.

Further work needs to be done to establish the future impact the project may have on the identified nutritional issues on the target population and how to continue this service. A recommendation is to make sure staff are aware of any potential anomalies or pitfalls on the paperwork where mistakes could occur.

Introduction

Aim of the project

The South Asian Weaning project was delivered by the Health Visitors within the Deighton and East Fartown Sure Start area in conjunction with the South Asian Healthy Living Partnership (a Healthy Living Centre funded by the Big Lottery Fund). The overall aim of the project was to develop a weaning intervention which was culturally appropriate and effective in enabling parents of South Asian origin to establish healthy weaning patterns. This is part of a response to address identified health problems that appear to relate to early nutrition. The project was funded for two years.

The purpose of this report is to set out the findings of an evaluation of the South Asian Weaning Project. The question being addressed is whether a South Asian Nutrition Worker can bring about changes in the weaning patterns of families with a South Asian origin that statutory agencies find difficult to reach.

The report begins by setting out the background to the project and explains the extent of the problem. It then sets out the project objectives and the nature of the approach undertaken to address the problem as described

The scope and focus of the evaluation will then be looked at explaining the limitations of the evaluation. The focus of the evaluation is to gain an insight into the views of families, the SAINW (South Asian Infant Nutrition Worker), health teams involved in the project and to triangulate these with the monitoring information collected.

Finally conclusions will be drawn as to the value of this approach and recommendations made.

Rationale and Background

The introduction of solid feeding and the gradual replacement of milk by solid food as the main sources of nutrition is the process known as weaning. In its recent publication the WHO uses the term weaning in a more limited sense to indicate complete cessation of breast feeding.^{1,2} Complementary feeding is the provision of any nutrient containing foods or liquids other than breast milk and includes both solid food and infant formula. In the UK the terms “weaning” and “complementary feeding” are sometimes used synonymously to mean infant solid feeding.³

The importance of correct weaning

Childhood nutrition is a major health concern. It is well documented that what we eat in childhood affects our health as adults⁴ with coronary heart disease, diabetes,⁵ cancer⁶ and bowel disorder⁷ being attributable to the effects of poor diet including that in the early years of life.

Other health problems also appear to relate to early nutrition. Dental caries, both the most common and preventable dental disease, results most frequently from excessive consumption of sweets, biscuits and sugary drinks between meals especially drinks given in a feeding bottle.⁸

A further concern is the extent of iron deficiency anaemia (IDA) that exists in the infant population especially within the inner city populations.⁹ Studies in England suggest that in some inner urban areas, despite the efforts of health professionals to address the issue, between 19 and 29% of toddlers have haemoglobin levels below 110g/l with corresponding low serum ferritin levels.^{10,11} These levels are of concern given the data

¹ WHO. Fifty-fourth World Health Assembly. WHA54.2. Agenda item 13.1. Infant and young child nutrition. Cited in Foote K.D; Marriott L.D. *Archives of disease in Childhood* 2003; **88**:488-492.

² WHO/NUT/98.1. Complementary feeding of young children in developing countries: a review of current scientific knowledge. Geneva: World Health Organisation, 1998. Cited in Foote K.D; Marriott L.D. *Archives of disease in Childhood* 2003; **88**:488-492.

³ Foote K.D; Marriott L.D. *Archives of disease in Childhood* 2003; **88**:488-492.

⁴ Kuh D; Smith G. When is mortality risk determined? Historical insights into the current debate. *Society for Historical Medicine* 1993; **101**:123. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421.

⁵ Fall C; Barker D. Growth in utero, blood pressure in later life and mortality from cardiovascular disease. *British Medical Journal* 1989; **289**: 90-93. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421

⁶ Frankel S et al. Childhood energy intake and adult mortality from cancer: the Boyd Orr cohort study. *British Medical Journal* 1998; **316**: 499-504. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421.

⁷ Chalcombe D et al. Changing infant feeding practices and declining incidence of coeliac disease in West Somerset. *Archives of Disease in Childhood* 1997; **3**:206-209. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421.

⁸ Pitts N; Palmer J. The dental caries experience of 5 year old children in Great Britain. *Community Dental Health* 1995; **12**:52-58. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421.

⁹ Booth I; Aukett A. IDA in infancy and early and early childhood. *Archives of Disease in Childhood* 1997; **76**:549-554. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421.

¹⁰ Gregory J et al. National diet and nutrition survey Vol 1. Report of the diet and nutritional survey 1995.. London: HMSO, 1995. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421

¹¹ Childs F; Aukett A et al. Dietary education work and IDA in the inner city. *Archives of Disease in Childhood* 1997; **76**:144-147. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421.

that IDA in infancy is associated with developmental delay^{12, 13} and that the cause of IDA in the population is largely dietary related.

When should weaning occur?

In the UK there is consensus amongst scientist and policy makers that weaning should not occur before 4 months of age, but there is a debate about the universal application of a policy to delay weaning until 6 months of age. The debate encompasses concerns about growth and nutritional adequacy of exclusive breast milk feeding for all infants until 6 months of age versus the risks, especially of infection, associated with earlier weaning.

At the present time in the UK, the Department of Health Recommendations remain, that for the majority of infants, weaning should commence at 4-6 months.

UK Practice

Despite these recommendations mothers in the UK tend to wean the babies earlier and only a minority breast feed for more than 10 weeks. For example, in 2000 the majority (85%) of UK mothers had introduced solid food by 4 months, and by the time their babies were 4-10 weeks old just a quarter of mothers were feeding their babies entirely with breast milk. The UK infant feeding 2000 survey found that mothers from ethnic minority background introduced solids later than white mothers and those of Asian, black, and other ethnicity were more likely than white mothers to have introduced solids after 6 months. In Muslim Asian populations, late weaning, the practice of introducing “doorstep” milk from 5-6 months, and the continued use of convenience baby foods, containing mainly carbohydrates, well into the second year of life may lead to deficiencies in iron and Vitamins A, C, and D.^{14, 15}

The extensive literature¹⁶ relating to the inadequacy of the weaning diet in some British Pakistani and Bangladeshi families suggests that weaning advice and support offered by routine Health Visitor contact to families is often ineffective.

Local Context

Birkby/Fartown is an urban area of Huddersfield, approximately two miles from the town centre. The area is deprived socially with higher levels of child poverty and unemployment than the national average and a high index of multiple deprivations.¹⁷ The Census of 2001 showed that the Birkby/Fartown area of Huddersfield has a high South Asian population.¹⁸

¹² Lansdown R; Wharton R. Iron and mental and motor behaviour in children. Report of the British Nutrition Foundation Task Force. London:Chapman &Hall, 1995. *Archives of Disease in Childhood* 1997; **76**:549-554. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421.

¹³ Oski K; Honig A. The effect of iron therapy on developmental scores of iron deficient children. *Journal of Paediatrics* 1978; **92**: 22-25. *Archives of Disease in Childhood* 1997; **76**:549-554. Cited in Griffiths B. A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 2002; **75**: 420-421.

¹⁴ Harris RJ; Armstrong D et al. Nutritional survey of Bangladeshi Children aged under 5 years in the London Borough of Tower Hamlets. *Archives of Disease in Childhood* 1983; **58**:428-32. Cited in Foote K.D; Marriott L.D. *Archives of disease in Childhood* 2003; **88**:488-492.

¹⁵ Gatrad AR; Sheikh A. Muslim Birth Customs. *Arch Dis Child Fetal Neonatal Ed* 2001;**84**:F6-8. Cited in Foote K.D; Marriott L.D. *Archives of disease in Childhood* 2003; **88**:488-492.

¹⁶ Sarwar T. Infant feeding practices of Pakistani mothers in England and Pakistan. *Journal of Human Nutrition and Dietetics* 2002;15:419-428. Cited in Smith S; Randhawa G.

Extending the role of the linkworker in weaning support. *Community Practitioner* 2004; **(77)**:146-9.

¹⁷ Department of the Environment. Transport and the Regions. Indices of Deprivation 2000. DETR.

www.odpm.gov.uk. Cited in Andrews L. Beakers for bottles-a health visitor oral. *Community Practitioner* 2004; **(77)**:18.

¹⁸ Kirklees Metropolitan Council Ward Profiles 2001. Birkby ward.www.kirklees.gov. Cited in Andrews L. Beakers for bottles-a health visitor oral. *Community Practitioner* 2004; **(77)**:18.

Anecdotal evidence of the Birkby/Fartown Health Visitors' indicates that the high oral decay amongst children in the area, especially among families of South Asian origin, is due to their poor weaning process. This is supported by a survey, (albeit a convenience sample of 50 clients) undertaken by the Health Visitors in 2002 of the local population.¹⁹

This has presented enormous challenges to Health Visitors in meeting the needs of this population. Much work has been undertaken to understand and engage with the community. In 2002, the Health Visitors planned and delivered a public health campaign, which involved the exchange of feeding bottles for beakers, toothbrush and toothpaste, and advice on oral health care. The vast majority of clients were receptive to the advice.¹⁶ It was recognised however, that a single event over one week, would not be sufficient on its own to change the weaning behaviour of families of South Asian origin. In 2004, a bid for further funding of the public health campaign and the running of a South Asian Weaning Project was successfully bid for from the South Asian Healthy Living Partnership (SAHLP).

Project objectives and delivery

The South Asian Weaning project is being delivered by the Health Visitors within the Deighton and East Fartown Sure Start area in conjunction with the South Asian Healthy Living Partnership (a Healthy Living Centre funded by the Big lottery) with the overall aim of developing a weaning intervention that is culturally appropriate and effective in enabling parents of South Asian origin to establish healthy weaning patterns. The project is funded for two years.

An experienced bi-lingual link worker has been appointed as a South Asian Infant Nutrition Worker (SAINW), within the Health visiting service in the Deighton and East Fartown Sure Start Area of Huddersfield. The SAINW role is to deliver evidence based weaning advice and support through one to one contact with families and the running of two group sessions.

Families who would benefit from the additional advice and support (those who fulfil one or more of the referral criteria are to be identified by the Health Visitor during their routine visits at 3 and 7 months, 1 and 2 years of age and are to be offered a referral to the SAINW via the referral sheet. The SAINW will provide the families with a minimum of 4 weaning advice and support contacts within their own home. This will be provided in addition to the normal health visiting service.

In addition the SAINW will invite all parents of South Asian origin to attend one of two group sessions providing information on correct weaning. Parents are to be invited prior to their babies commencing weaning at 4months.

Training is being given by Health Visitors to equip the SAINW with the skills to work independently, visiting clients in their own home and to be component to offer appropriate weaning advice.

Scope of the evaluation

There has been limited research undertaken on the effectiveness of using link workers in providing weaning support for families of South Asia origin. Only one previous study has been identified,¹⁶ the limitations of which have been acknowledge by its authors. These include the small study size and the uncertainty as to whether a similar pattern of visiting,

¹⁹ Andrews L. Beakers for bottles-a health visitor oral. *Community Practitioner* 2004; **(77)**:18.

for example, Health Visitors would achieve comparable outcomes. However, the study does strongly suggest that this kind of approach could be usefully applied.

On the basis that there is some evidence (albeit limited) on the effectiveness of using link workers, this evaluation is not about testing a hypothesis that SAINW's are more effective than Health Visitors at delivering weaning messages to families of south Asian origin. Nor is it about evaluating the project against the indicators of success identified by SAHLP. This evaluation is being undertaken to provide information to the Public Health Directorate within the two Huddersfield PCTs as to whether the project should be mainstreamed once funding from SAHLP has ceased. The evaluation is about assessing whether this particular type of approach of delivering weaning messages either in the clients own home or as a group has added value to those families and health care professionals within the Deighton and East Fartown Sure Start Area of Huddersfield

Evaluation Purpose

- To measure whether the project achieves the targets and indicators of success as identified per the (SAHLP) monitoring pack.
- To provide information on the success of the project for potential mainstream funders.

Evaluation Question

The question being addressed by this evaluation is whether a SAINW can bring about changes in the weaning patterns of families with a South Asian origin that statutory agencies find difficult to reach.

Evaluation Objectives

The evaluation objectives have been determined from the above evaluation question. They are set out below in relation to the groups of people whose behaviour the project is aiming to have an impact on.

Mother

- To determine the number of families who participated in the project
- To determine the number of families who withdraw from the project and the reasons why
- To understand why parents/families participated in the project and what their initial expectation was
- To explore what the parents understanding of the project is and why it is taking place
- To understand mother beliefs about the weaning process and any barriers they may have faced.
- To understand what factors/sources of information affect the way in which they wean their child
- To explore whether there has been any changes to the way in which they have weaned their child(ren) since the project began and the causes of these changes
- If the mother has had more than one child, to explore whether there has been any differences in the way that she has weaned the child involved in the project compared to her other children and the causes of these changes.
- To explore the causes of these changes if any.
- To explore the views of the mother on the weaning advice and support offered by the SAINW and if their experience allows to compare it to that delivered by the Health Visitor.

SAINW

- To explore any areas of good practice they have identified during the project
- To identify any barriers they have encountered in delivering the project.
- To explore any concerns that they had about delivering the intervention at the outset or during the project.

Health Visitors

- To explore what barriers /difficulties they have encountered in the past in delivering the weaning information to families with South Asian origin.
- To explore their views on whether the project has successfully fulfilled its objectives in enabling parents to establish their children on healthy weaning diets
- To explore their views in relation to the use of 'unqualified workers' during the project time
- To explore their views on the amount of time required to inform/support/ mentor the SAINW in her visits
- To explore their views on the change in their role from direct client contact to on going supervision and training of the SAINW
- To explore their views on whether the use of a SAINW has had an impact on caseload management and their ability to meet contractual obligations

Methodology

The methodology to be used will consist of both quantitative and qualitative techniques. They are set out below in relation to the groups of people whose behaviour the project is aiming to have an impact on. Triangulation of data will be undertaken whenever possible.

Mothers

- Mixed approach (Quantitative and Qualitative)
- Determine the number of families (and drop out rates) using the SAINW through collation of the SAINW Contact Monitoring sheet (Appendix 2)
- Documentary Analysis of Family plans (Appendix 3) to identify a group of families who have established children on appropriate diets and a group of families who have not. The analysis is to be triangulated against the findings of the focus groups.
- Focus groups to be used to obtain ideas about the projects effect on the weaning process from the clients perspective. 1-2 focus groups (each focus group consisting of 6-8 mothers) will be held depending on the number of clients willing to take part. 2 focus groups were held for those parents/families who have successfully established an age appropriate weaning diet.

SAINW

- Qualitative approach
- In-depth interview

Health Visitors

- Qualitative approach
- Focus group consisting of both Health Visiting Teams within the Birkby Fartown Area

The following groups were completed

- Mothers
- SAINW
- Health Teams

Analysis

Quantitative

Analysis of differences in incidence rates of infants established on a healthy age appropriate weaning diet will be made to the control incidence rates.

Qualitative

Data from focus groups, in-depth interview and structured telephone interviews will be transcribed and contents studied for emerging themes, common ideas, contrasts and similarities, and analysed using thematic content analysis.

Documentary Analysis – Monitoring Data

Monitoring data for the project consisted of initial data about the family collected at the point of referral by Health team, this included identifying the problem and setting the level of priority (1-5 with 5 being the highest need). Data was also collected following the visits by the SAINW using the family intervention outcomes sheet.

The process:

- Health Visitor agrees with the family to refer the SAINW
- Reasons for referral identified by the Health Visitors on referral form (appendix 1)
- Priority allocated by Health Visitors
- Notes and discussion between Health Visitor and SAINW
- SAINW and family agree plan (appendix 3)
- Support available from Health Visitor

Out of the 45 referrals there are 31 positive outcomes recorded. The mothers talked about the changes in their thinking and actions after the SAINW intervention, positive changes around confidence, knowledge and the application within the family.

There were 14 referrals where positive outcomes had not been recorded, 5 of these were still ongoing at the time of evaluation. At the time of evaluation the outcome data on 4 of the original referrals was unavailable. The remaining 5 were classed (for evaluation purposes) as having questionable outcomes, for example although the family/mother reported that the information and suggestions were being implemented the SAINW was not sure that this was the case. The quote below is taken from a family outcome report completed by the SAINW:

“Mum was not aware of BOGH (Balance of Good Health) model & weaning in general. Feel that mum has got a bit more knowledge about the types of food to be given. Although dad seems to be the one who tells her what to give the child. Discussed the importance of balanced diet with dad also”

Another example in this group of 5 had unclear outcomes due to the fact that the original referral reasons had been crossed out.

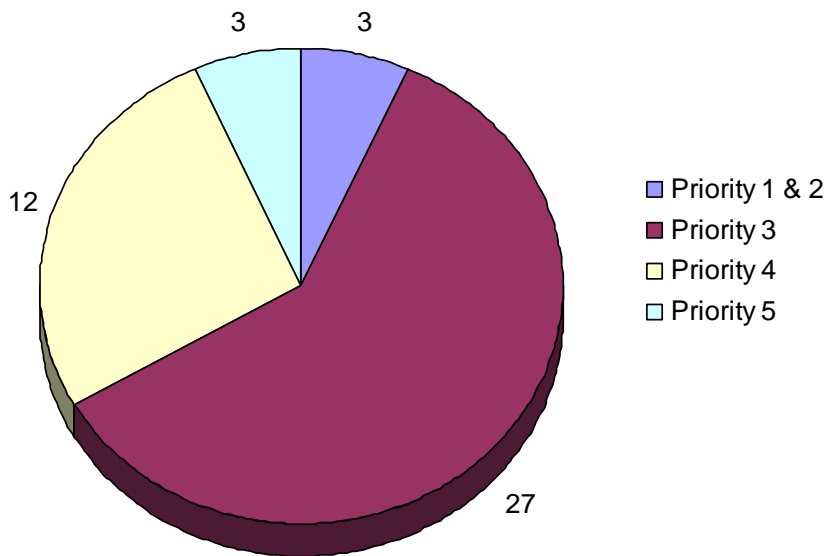
Limitations of data & data validity issues

A limitation in the data was found on one of the monitoring forms due to a misprint that resulted in referral numbers moving down against the referral reasons, e.g. referral reason 1 – _____ was printed as referral reason 2 – _____. If this happened regularly it would create anomalies within data. Also, the quality of the data set was questioned when an anomaly was found for the recording of referral reason 13 – *Nutrition problem with previous child*. Of the 5 referrals identified as 13, one of them should have been referral number 21 – *requesting support and guidance through the weaning process*.

There was however clarification in the notes section of the referral

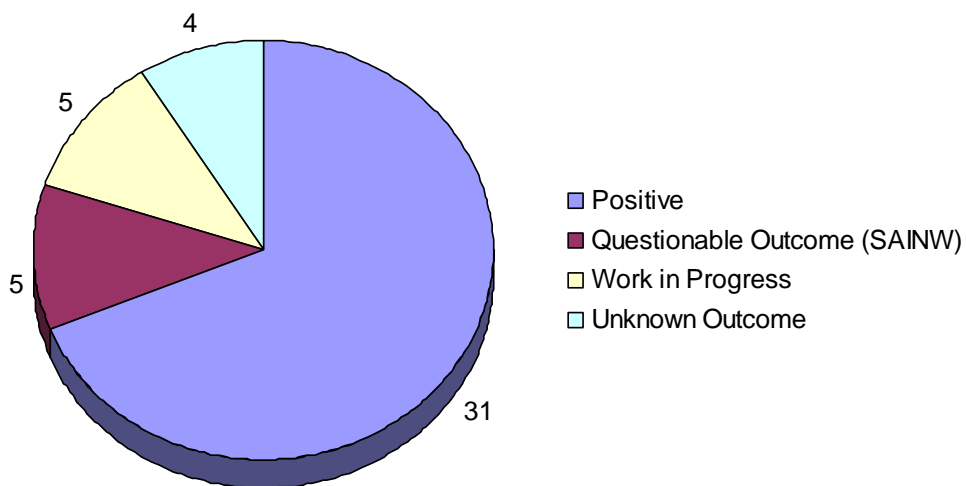
Main Findings

Priorities of Total Referrals



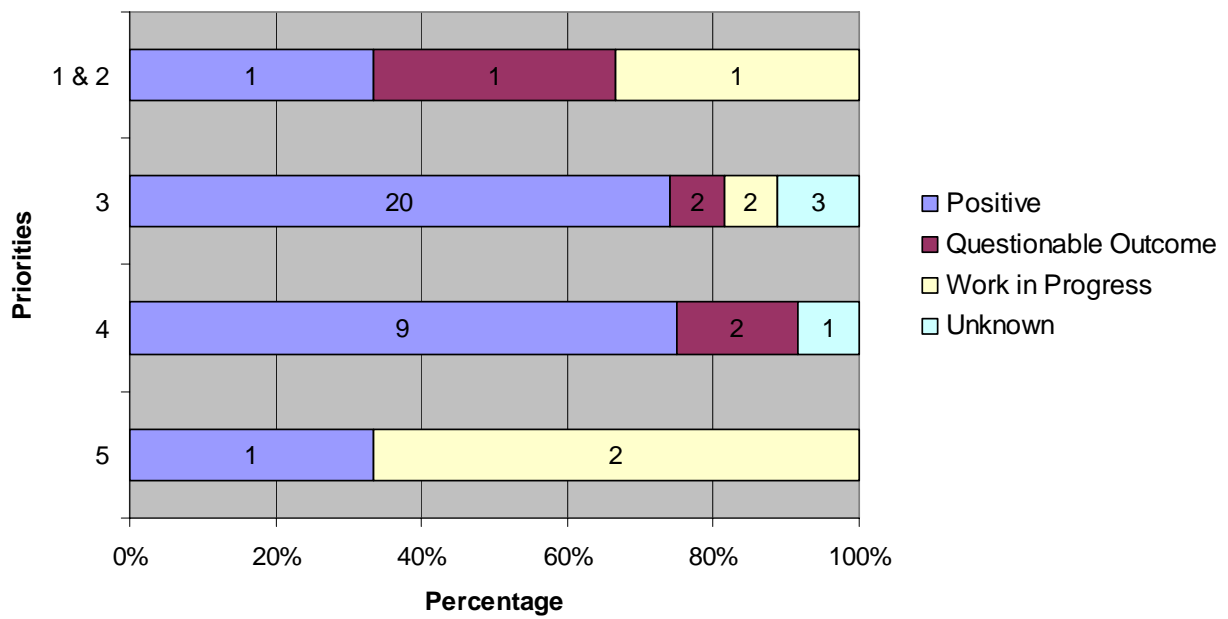
This chart shows how the Health Visitors prioritised referrals indicating the majority fell into the mid range band.

Outcomes of Total Referrals



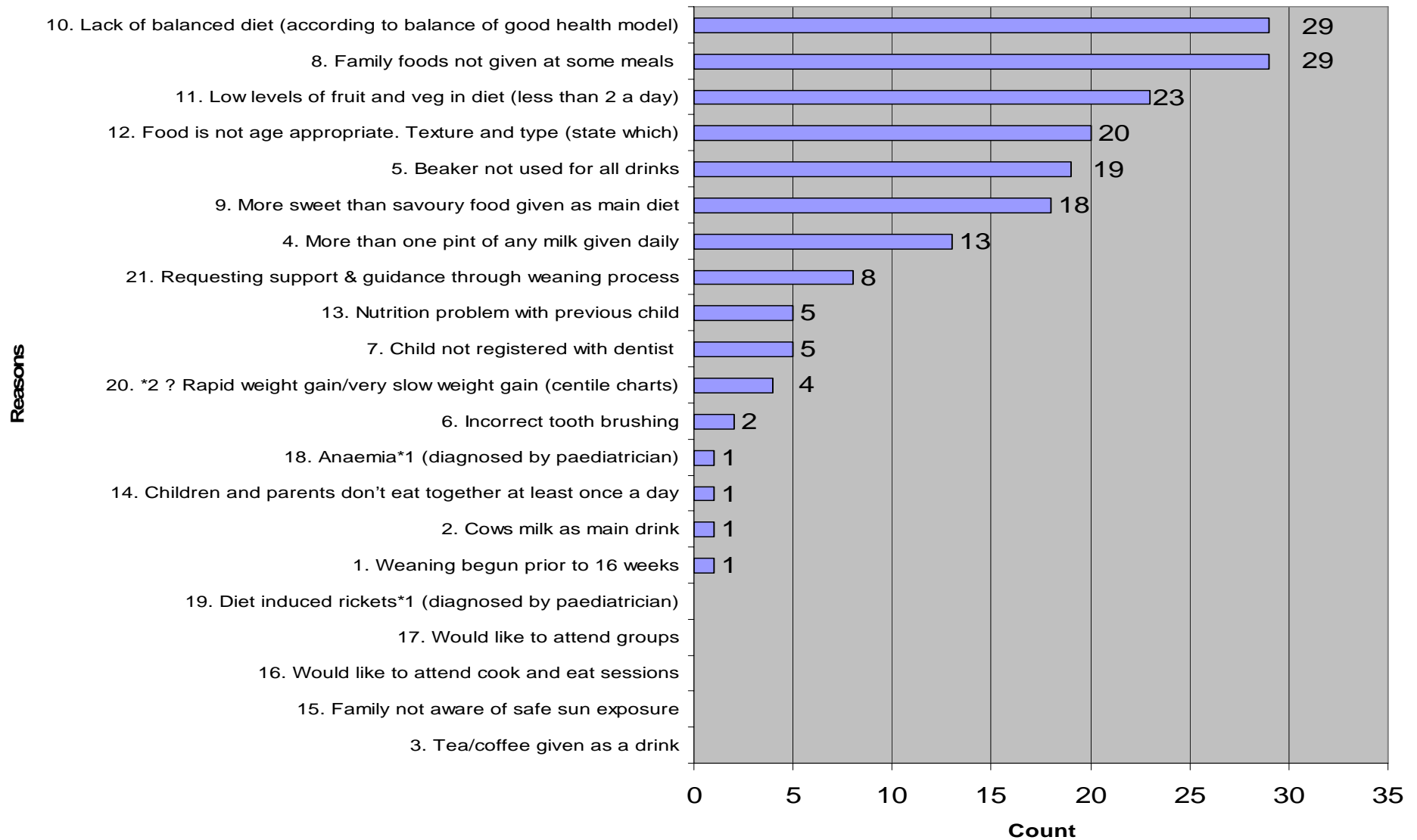
The outcomes of the total referrals show that the majority had positive outcomes. Questionable outcomes are where the SAINW was unconvinced of the families reported behaviour change. Work in progress is due to the vacant SAINW post. An unknown outcome represents data unavailable at the time of evaluation.

Outcomes Linked to Priorities Overall



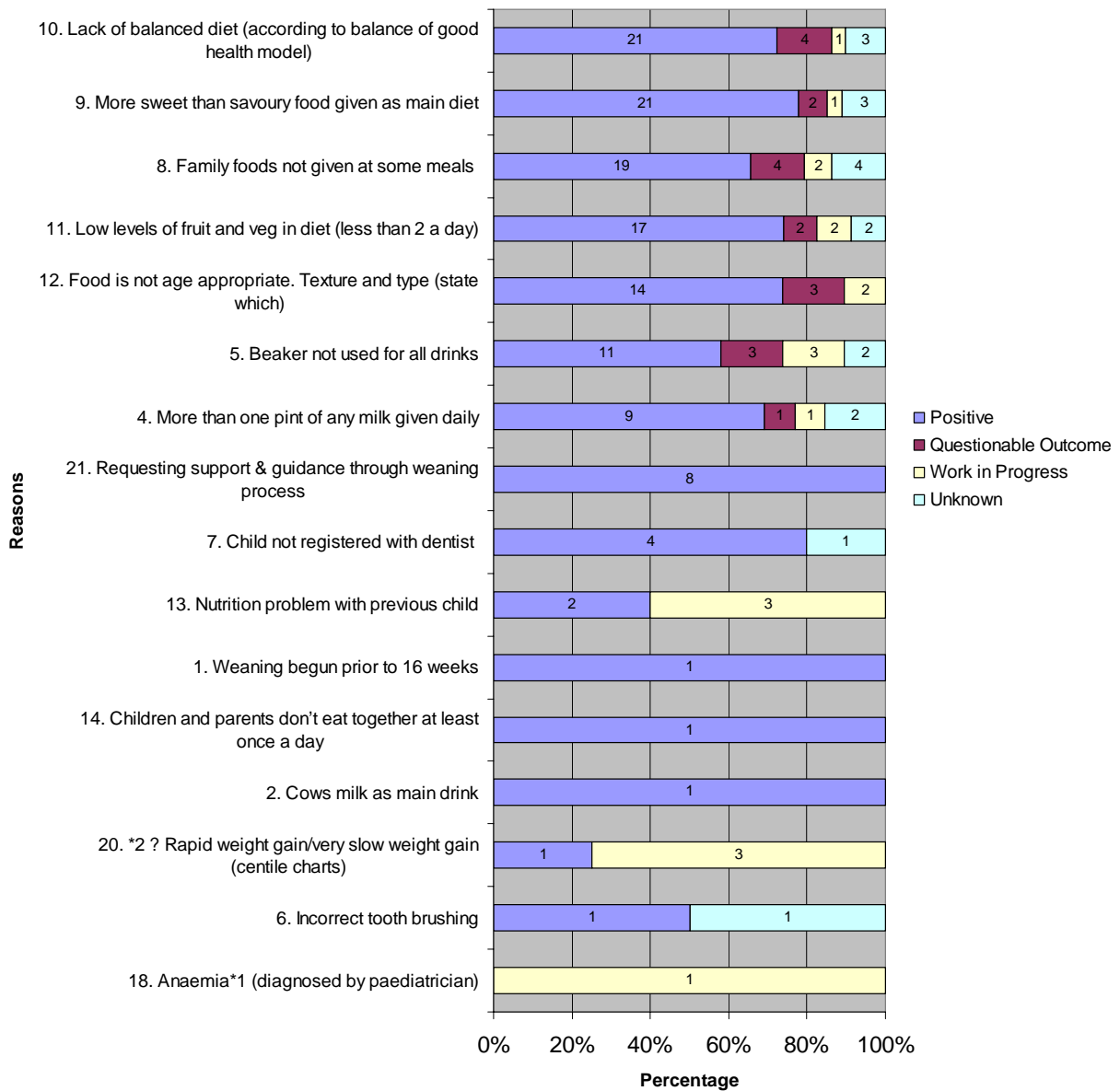
This chart looks at differing levels of success between the priority bands.

Overall Reasons for Referral



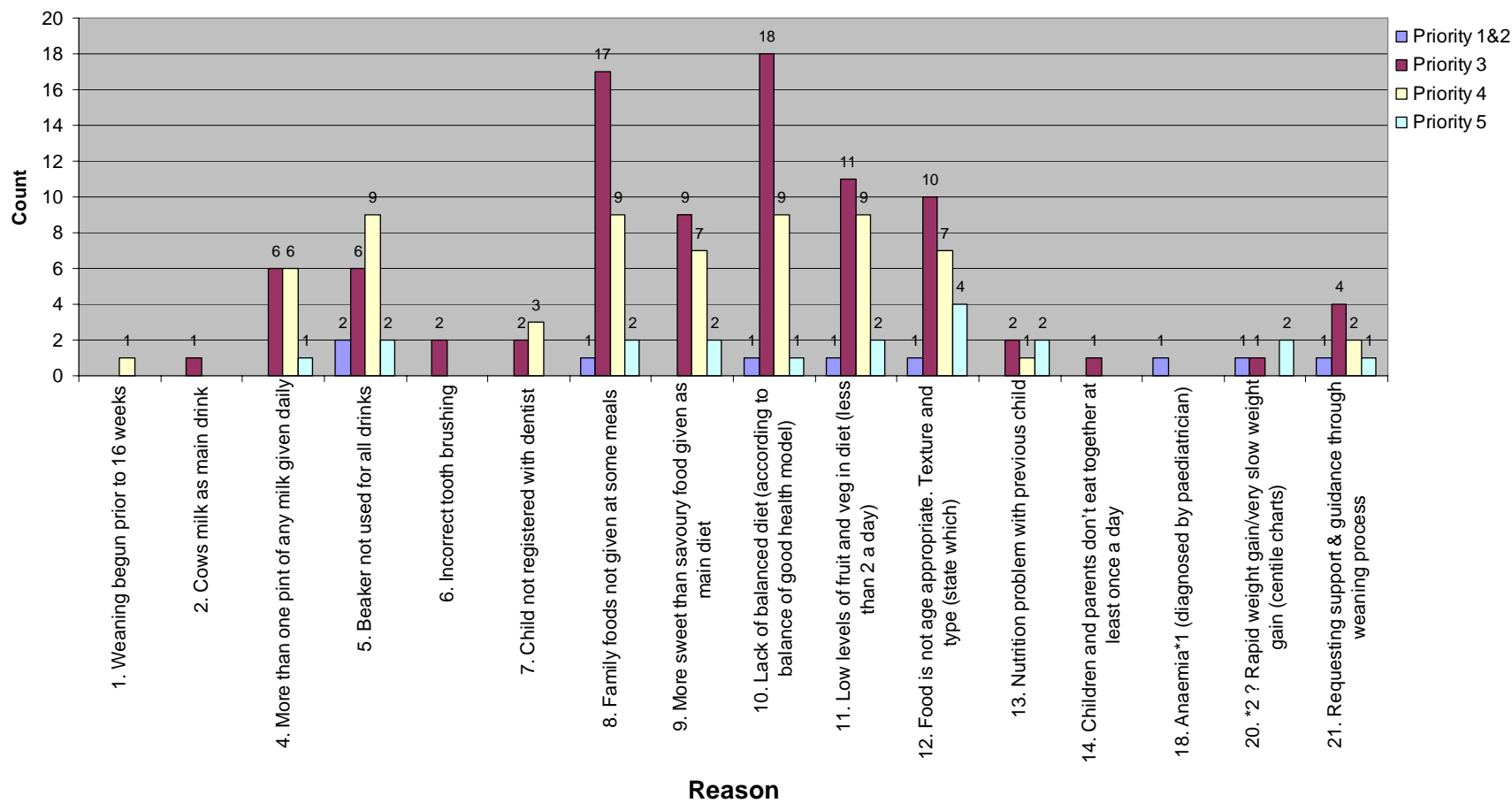
This chart looks at reasons for referral and it is worth noting here that families may have been referred for numerous reasons explaining why the total reasons are more than 45.

Reasons for Referral - Outcomes



The chart shows the outcomes of the total referrals showing some with 100% positive outcomes. The most common problems (i.e. 10, 9, 8, 11 & 12), experienced differing levels of successful outcomes.

Reason for Referral Linked to Priority



There is some difficulty around analysing the information in this chart. For example when looking at the priority levels given against reason 4 - More than one pint of any milk given daily, there is an equal number of mid range and mid to high range with one high range priority, but it must be remembered that the priority bands can be given against more than one referral reason.

Summary

The documentary analysis indicates that the project has had some success in producing positive outcomes for families to address their reasons for referral. The reasons for referral also highlight that the project is addressing local health concerns, capturing the original aims.

Analysis of Focus Groups with Mothers

To gain the views of families who had taken part in the project, two focus groups were held. The families were asked at the outset of the intervention whether they could be contacted for evaluation purposes. Logistical issues had to be taken into account such as access to the focus group location, timing and crèche facilities; the need for a bilingual facilitator and translator; and consideration of other cultural aspects. These issues all had an impact on the availability and numbers of parents able to attend. Both groups consisted of mothers only and one group was non English speaking.

The issues to be addressed by this aspect of the evaluation process included gaining a baseline of current knowledge and understanding around healthy/unhealthy issues (including food) for babies and young children and where they had or would acquire information or advice. They were then asked to discuss changes or effects the intervention may have had on the feeding practices including going through transition stages, their views on the value of an individual to support them, and if their experience allows them to compare it to that delivered by the Health Visitor. Both groups were also asked how they would deliver information about food, nutrition and weaning to members of their own community. The discussion guide for these groups can be found in the appendix 4.

Positives and Negatives of being a Parent

Both groups were asked to think for about their roles as mothers and the positives and negatives they could associate with being a parent and then to write down 3 of each. These have been captured in the following diagrams.

Diagram - Positives of being a parent

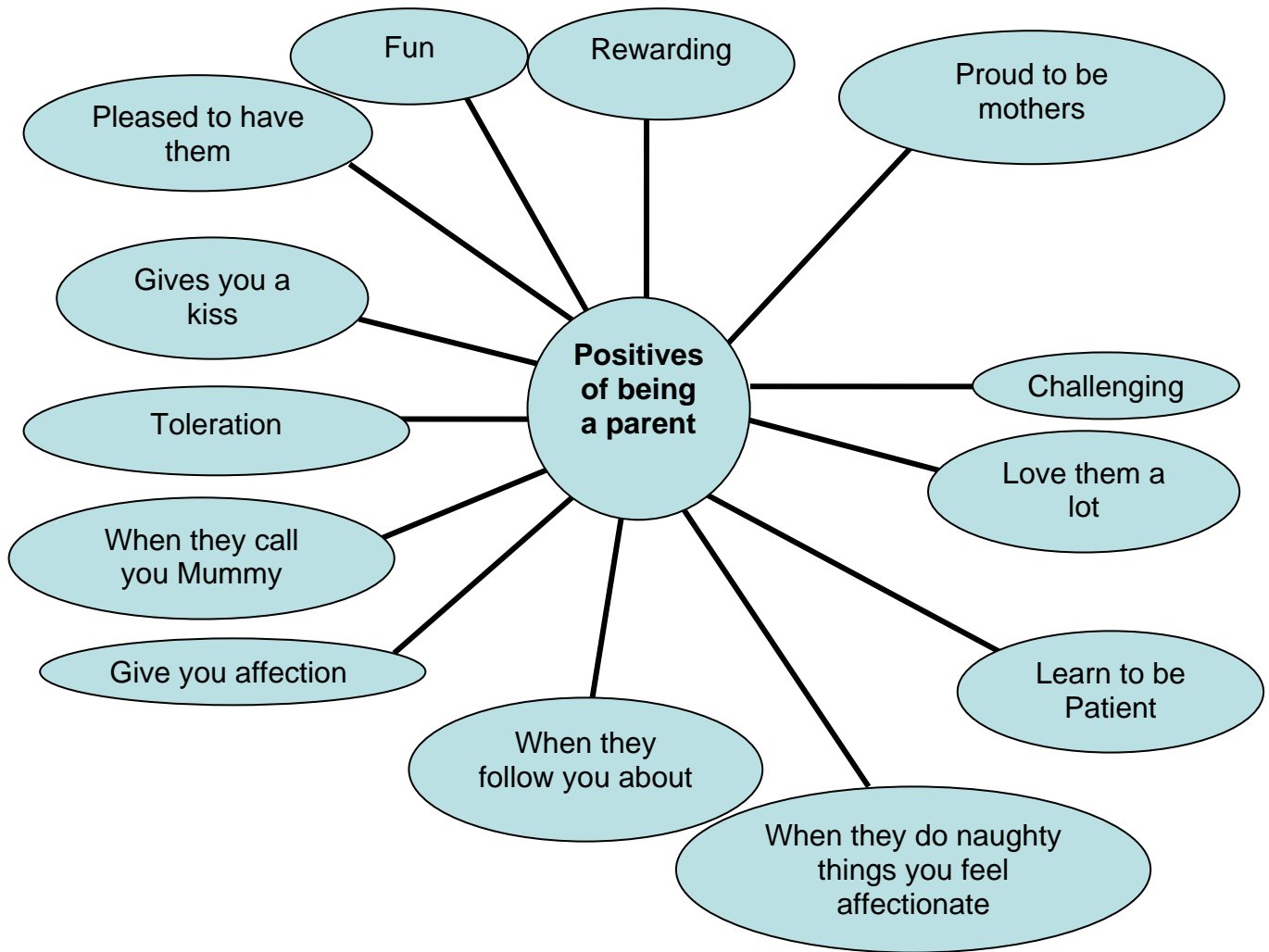
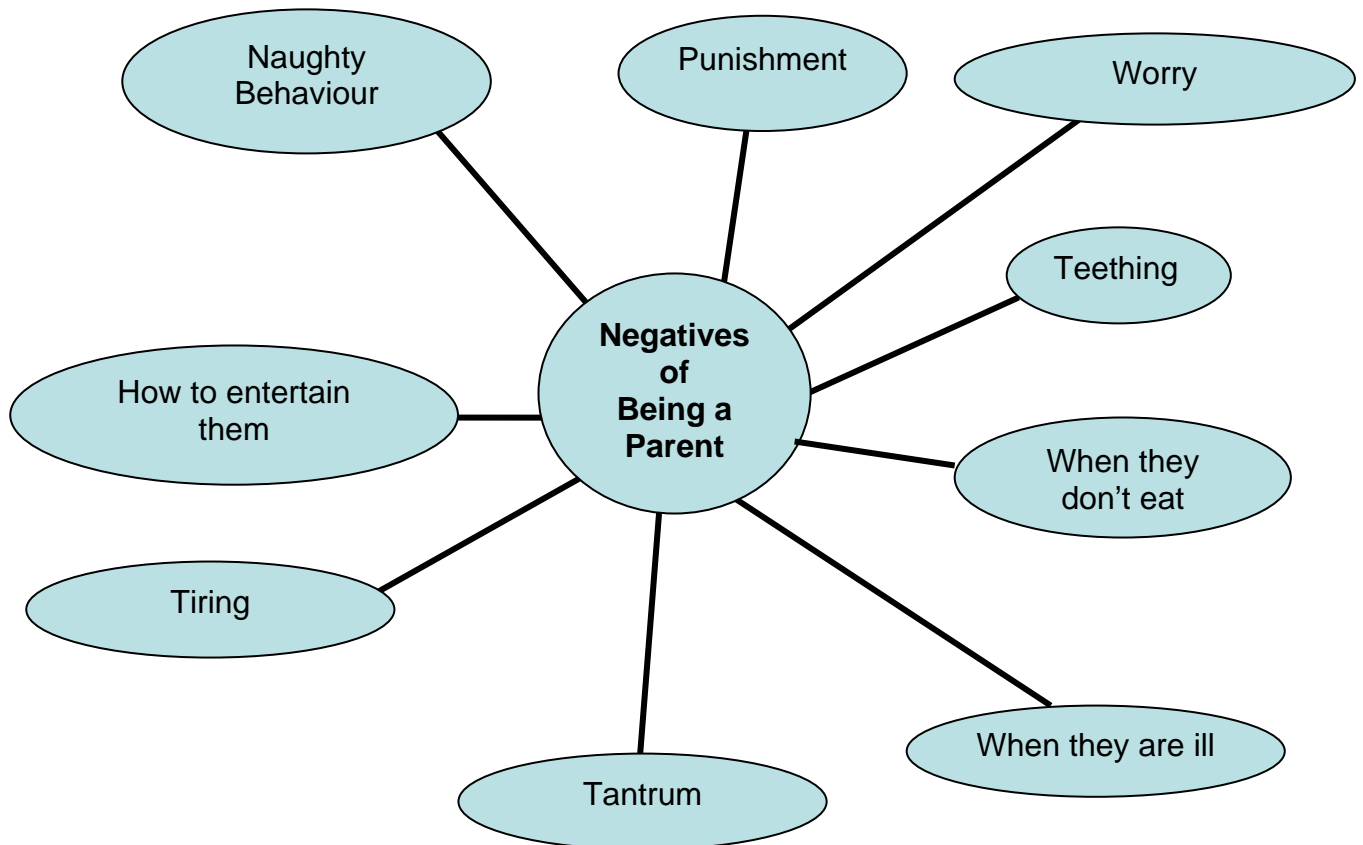


Diagram - Negatives of being a parent



Current Knowledge

The mothers from both groups were given some time to think about and discuss with each other what they thought was both healthy and unhealthy for young children and babies. Some clarification was required as to whether the question was general or specifically about eating.

Healthy	Unhealthy
Vegetables Meat Fish Chicken Five fruit and Vegetables Milk and Water Cereal + Milk fills you up Home Cooking Meal Routine Sweets after a meal not before Cooking in oil rather than water Having Breakfast	Fizzy Drinks Sweets Chocolate Fast Food Take Away Food Red Meat
Reading and playing Discussing things with children Leisure Activities, sports	TV Computer Games No sleep routine Very Quiet Children

The above points were expanded on, both groups mentioned 5 fruit and vegetables as healthy, one mother talked about encouraging her children to eat fruit by preparing it for them.

“...I’ve noticed that if I cut it up for them they will eat it”

She also talked about how the school encourages children to record their fruit and vegetable intake as well as providing them with free fruit at school and how tuck shops used to sell chocolates, crisps and sweets.

Another Mum talked about diet.

“I think it’s good to give a child vegetables, meat, fish”

Both groups were in agreement in thinking that home cooked foods were healthier than take aways and fast food and the various reasons for this were around hygiene, unknown levels of salt and “oily things”.

“Fast food, that’s not very good for a child’s health”

They favoured home cooked meals, as they knew what had gone into it and how fresh the ingredients were. One of the mums pointed out that a baby being weaned can’t eat take away food.

“...so its best if it’s all cooked the same for the whole family”

The ready prepared meals from the supermarkets were not really seen as an option as they are rarely Halal, and one of the mums said that the only jars of baby food she would buy occasionally if taking the baby out somewhere, would be vegetables and fruit. When asked why they thought fizzy drinks unhealthy one mum answered:

“Too much sugar”

Another mum had her own evidence of fizzy drinks affecting her son’s behaviour and lack of concentration.

“Yeah he can’t sit still and he can’t concentrate”

However, milk was seen as healthy for growth, teeth and bones, due to the calcium. One mum thought water was good for helping with the digestive system and preventing constipation. Along with home cooked meals, having a routine supporting children’s eating was seen as a positive thing. Breakfast, particularly cereal with milk, and giving deserts or sweets after meals rather than before were also identified as important.

“you should feed children with a routine.....and don’t give them things in between...”

“...and if they don’t have breakfast they are not going to concentrate well at school...”

“Desert after a meal, sweets after a meal not before”

In one of the groups there was a discussion around Asian cooking and the choice between butter and oil, it was felt that traditionally butter had been preferred as it made the food richer and some people had felt it gave a nicer aroma and taste to the food. But one of the participants of this group went on to talk about the advantages of using small amounts of oil.

“But I think basically the oil is much better because its, you can digest it properly, you don’t have the problems with asthma and if you eat something with butter it tends to go really sticky....”

One of the groups felt that sweets were tempting both for themselves as well as the children.

One of the mothers stated her children were seeing the dietician and for her children she identified red meat as being unhealthy.

More general areas were discussed including discussing and talking to children to try and anticipate any problems or issues, how children can learn both good and not so good behaviour by copying each other.

Understanding Stages

The mothers were then asked to describe how they had known it was the right time to wean their children.

“I’d give him like 5oz of milk and he was like going three or four hours just on 5oz milk and then it was like two hours and he be hungry again and crying...and putting his fingers in his mouth and then we did start weaning he was more settled having milk and then having a meal cause I felt that he was more hungrier”

Nighttime milk feeds were another issue raised by some of the mothers as to why they had started weaning.

"I had her on milk then all of a sudden about four months I realised that she was getting up in the night, I didn't want to give her a feed of milk I haven't done that with my others you know in the night time"

"I feel like you learn from your mistakes. With my eldest son I use to give him a bottle at night every time he woke up. I would say here's a bottle of milk you know and then when I was trying to potty train him it was so hard. He was really difficult because he was drinking at night and then weeing and I thought I can't do this with the others..."

The type of milk that the mothers used before or during the weaning process varied.

"The container one. Cow & Gate"

"I used the other one, SMA. The Cow & Gate one gave him stomach pains"

"Mines on a special milk...because he had quite bad reflux"

"I use Cow & Gate premium now with my daughter even now even though she's turned one I'm still using it, but I do use fresh milk in her diet. I did try breastfeeding but I think its so hard I really did envy them that can do it, I did find it really hard but if you can do it it's really good. It really got me depressed"

"I breastfeed"

The mother who breastfed also pointed out that the child would no longer take her milk since she had started weaning.

The amount of milk that the children drunk also seemed to vary.

"So the milk decreases and the food increases..."

"My baby drinks it once at night at two or three o'clock but not during the day, because he didn't drink a lot when he was little and now only at night."

"Well I'd say even now with my ten year old I encourage him to drink. I think for everybody we should have at least a pint of milk a say you know"

"Because milk isn't harming is it? The more you drink it the better for you it is so it makes your nails and stuff stronger as well..."

The mothers were then probed about the food that they had used to initially wean their children.

"I started to give baby cornflakes, you put them in milk and make them like rice pudding"

"...I went and bought some baby rice and gave her that just before she went to bed with a bottle of milk..."

Next Stages

The stages after the mothers had decided to wean their children were then described.

“When they are six-four months you start to give a little bit of food, when they are four months, a bit of baby food you start to make at four months. By six months they are eating it nicely so you give them food, and then give them milk to drink. When they are one, whatever you are eating they should try to eat that instead of baby food. Chapatti, whatever we eat, Asian food...”

“Seven or eight months that they should eat all our things. It doesn’t happen quickly, it doesn’t happen that quickly, from one year old he has started to eat properly”

“Well I started off at first with the baby rice, it was just at bed time for a couple of weeks I went on like that and then I started breakfast and bedtime and then during the day she was having milk and then gradually I just started building up and like now she’ll have sometimes like three or four feeds...”

The frequency of feeding at four months varied between one and two feeds building up to two to three feeds by the time the child was eight months.

Some mothers also pointed out that the children needed variety and a mixed diet.

“He won’t have just salty or just sweet. Nor will he eat egg and bread everyday and nor will he have chapattis everyday. It has to be mixed”

“It has to be mixed everyday, sometimes egg and bread, sometimes a praughta” (thick chapatti often with a filling)

Once the mothers had started to wean their children they were then asked whether they cooked special or separate meals for them.

“Well mine is really young at the moment and we eat like salt and chillies and stuff in our food so what I do is just take whatever meat we’re using, chicken or mince or whatever it is, I just put it on the side and don’t put any of the salt or whatever in it and let hers cook on the side and let whatever we’re going to eat cook on the side and then she’s getting hers as well.”

Whereas some mothers pointed out that they had actually altered their own eating habits to make the food more suitable for the children.

“I mean before we used to eat it quite spicy, now we have reduced the spice/chilli”

“Yes we’ve reduced the chilli or don’t put it in the food”

“Yes make it for the children and they don’t eat it, that will go in the bin, so its better to make your own food and reduce the spice”

There seemed to be a general agreement between the mothers that they considered home prepared and cooked food to be better for children than tinned and store bought food.

“You don’t know how long it’s been there”

“And to put the seal on you don’t know how many chemicals have been used...and that’s not good. I give my kids home cooked food I have never given them outside food. Yes tins of custard with sugar but mostly vegetable, chicken, meat I have made at home”

The mothers were probed around their child’s routine and where they would normally feed their children.

“In the kitchen we have a dining table and we put his chair up against that and we eat there and that’s where he eats, but I feed him and then I eat, and his dad and his grandmother and grandfather sit and eat there as well, and I feed him and then I eat after all of them”

“Mine is still small so I feed her but she does eat with us, now she wont sit in her chair, she says give me a chair at the table and I want to eat alongside them...she sits and eats on the chair with her sisters”

One mother was keen to emphasise the importance of eating together.

“The children develop a relationship/love with their parents if they sit and eat together. If you feed them at different times, if you feed the girl at one time and feed the boy at another time, you don’t have with the parents or with each other that same loving relationship. You feel separate I think”

The issue of eating together influencing the child to eat was also raised.

“I try and talk to him and make him understand and I don’t get anywhere but when he looks at other children doing it he gets a lot further”

“You know they feel like my mother is eating, my father is eating and my brother is eating and I should quickly eat”

The amount the children ate was in many cases left up to the children.

“He understands but can’t speak but when he doesn’t want to eat then he shakes his head and says I won’t put it in”

“Mine is like that she will eat how much she want to eat and then after that she wont have anything”

Mothers explained that they had received the information regarding feeding from various sources.

“The Health Visitor when you go to the class, when they call you, when you have your first baby the Health Visitor...they come to your house and there is a special class at Fartown Health Centre”

“Only if there is an elder can they tell you”

“Some friends will tell you who have older children”

“Who have older children, you know who have older children and have the experience and can say our child did this and wouldn’t eat this, or this happened and they can advise you, don’t do this, try this. Family and friend”

"I have had support with my mother in law"

"Mine was a dietician for the younger one..."

The mothers had also all received some kind of support or advice from the South Asian Food and Nutrition worker.

"...there is Sure Start's SAINW, we know of her and she comes to the house, and she tells you about the child, she helps a lot, how you should feed them and what to do..."

"She came once and told me all about how to feed him and then she came to find out how it was going"

"She advised me everything to be honest with you she does because I am from back home you know so I'm not from here like you lot, so its more harder for me you know to understand child, you know what they want so she helped me every angle basically..."

Value of Project

All of the parents that took part in the focus groups had been visited by the SAINW and had positive comments. The SAINW was involved with parents having problems weaning/feeding their children.

"My youngest wouldn't eat cheese, she had an allergic reaction to it and SAINW told me to try cutting out the cheese and then when we cut it out there was a difference.

Moderator: *"Then is that why she came because she would not eat?"*

"She wouldn't eat"

Moderator: *"Anything?"*

"She wouldn't eat anything and then she came and I told her that I thought it was with cheese this was happening, and she said try cutting it out and see what happens if it is with cheese or with something else."

Other parents explained that the Health Visitor had referred them to the SAINW.

"there is Sure Start's SAINW, we know of her and she comes to the house, and she tells you about the child, she helps a lot, how you should feed them and what to do... if there is a problem the first person we go to is the Health Visitor, the child wont eat and then she sends her"

And also:

"The children would not eat, at first I took them to the Health Visitor and she advised...I will send a trained lady."

Parents explained that the SAINW gave them support around the best diet for their children through different stages of weaning, help with specific problems e.g. child not eating or how much fruit & vegetables to give children, and this was given to parents in their own language.

"Well basically what she helps with is just advises you on how to make the Asian foods, what to use and what to put in your foods and what not to put in your foods, so first when she came to me, she told me like to make the foods pureed, a puree kind, cos she was really young at that time, she was about 4 and a half months, but then the second time she came, she says right start making it a little bit lumpy and now I'm just making it like I'd make my own, like I'll make a curry and put a chapatti in and let it dissolve in there, so its slightly lumpy, or I'll like give it her with bread so its really helped the way she advised me through it all."

"with me it was cos I wasn't sure you know how much fruit and veg to give him you know so she was like telling me that the palm of his hand, like five portions for us is like a full apple a full banana and a full pear, but for him it was like what would fit in the palm you know of his hand"

"She said that let them eat themselves, when they are one years old, let them eat themselves. You are like, she said to us that you want to feed the baby. I wanted to feed my baby because she makes a lot of mess when she eats; she scatters everything and throws things on the floor."

"She's given me loads of recipes like Asian recipes." And "Yeah she gives you everything like in your language as well."

One parent described the SAINW as *"an Asian Dietician"*.

The SAINW also helped parents with other issues such as potty training and children's behaviour.

"Yeah she told me everything and she told me how to potty train him as well!"

Parents were given recipe books and leaflets by the SAINW and there were mixed opinions with regard to the information given out.

"I thought they were going a bit over the top, you know, obviously everybody has their own knowledge, you're not going to put a pack of chillies in and give it to a baby you know, I think they were sort of going a bit over the top in that sense, you know because you sort of basically know yourself you don't put salt in and you wouldn't put sugar in."

"I'm from back home you see I don't know how much salt is good for the children, you know because in the school I don't learn that, so I don't know I just learnt to my Mums how they teach, how they treat with the children's, so I really need that, to know exactly how much."

The SAINW's visits were generally greeted with a positive response and seen as useful for parents.

"Yes I thought it was very good that she came because I didn't know how to treat my child. A mothers heart is soft and she thinks oh god my child hasn't eaten and if someone tells you, tells you properly that no you shouldn't do this, then you take more notice, that yes I should try to do it the way she has told me. I thought her coming was a good thing."

"Well because she was a mum herself, you wouldn't really look at her as some to come and advise you, it's like your just talking to another mum and sharing ideas and experiences with each other."

“She’s more mature than you and her children’s more mature than you and she already been that process so she know that what she doing.”

“The children from here they already know that because they have the school and they’ve grown up here and they know more about it, we don’t know that.”

Parents in both groups mentioned a method of introducing Asian food to children and this included reducing the spice and salt content of foods.

“She said to me when we make the masala for the food, take a bit out for the baby and some for yourself...put salt and chilli in your own and reduce it in the other.”

“She really came to tell me that ‘look you can introduce your own foods just knock the salt and the spices out, or just put mild spices in for her’ and then hopefully that would work.”

Parents also mentioned about that the SAINW’s advice made cooking cheaper and healthier.

“It is definitely cheaper”... “It’s not just being cheaper, it’s healthier as well”... “It’s cheaper in that sense and at least you know what’s going in and everything.”

When asked if anybody else should be given weaning information, parents suggested that fathers and grandparents should be made aware. The reason for this was to have more support in rearing their child and, in the case of grandparents, support for the mothers methods.

“I think they should be trained... I think there should be a dad’s class, you know they should be trained on how to pick up a child and give them milk with the feeder.”

“And when the mother is ill the father should look after and how to look after...this should be told especially to Asian men”

Although this wasn’t the case with all the women:

“My husband is very good”

“If there is a joint family system, there is a grandfather, grandmother, the grandparents live with you. Especially the grandmother they should know that if the mother is punishing her child, or wants to feed them a certain way they should not interfere.”

Changes in Weaning

The groups were asked to think about any changes that may have occurred since having contact with the SAINW various aspects of these changes emerged, including changes in routine, differences between how their children were fed and weaned before any involvement with the project and then subsequently, they found the guidance given was useful and realistic to achieve, although some had faced difficulties with other family members not following the guidance given. They felt the information they had been given enabled them to cook their own food for young babies and children and made that choice healthier.

It would seem that a couple of the mothers had less worry and felt more confident, for example in just letting the child eat as much as they want and not trying to force them to

eat to put weight on and noted that some parents could become obsessed with lack of weight gain in their babies and advocated they should be more relaxed about this.

"...ok you're going to prepare it yourself you know it's healthy...."

"I'm not worried anymore, before I was worried all the time.....what she told me I did and that for me was the best"

When the groups were asked if being in contact with the SAINW had changed the way they thought about feeding children the answers were different but positive.

"Yes definitely"

"She's like an inspiration"

"It's changed, my own routine has changed, I have changed my own food we didn't have that much healthy food before..."

"Yes I have a set routine, not listening to my heart, keeping her hungry all day, like she said, all the things she said to me I listened to and my daughter is ok now. I'm not that worried anymore, before I was worried all the time....."

"What she told me I did and that for me was the best"

However two of the mothers stated that they felt family circumstances made it difficult for them to instigate the advice they had been given and set a routine for the child. This was due to the fact that other family members, who had care of the children when the mothers were working or out, didn't follow the advice.

"sometimes the grandmother gives her milk, sometimes crisps, sometimes some fruit.....and she will keep putting things like that in her mouth"

Further probing confirmed that no changes had occurred in her household because of the influence of the family member.

"Yes the routine has never been set"

Another mum confirmed this, and explained that she had returned to work and the baby wasn't kept to the routine that had been advised.

"Whenever he cried, let's feed him something, that's why he's crying..."

"So I left work and I feed him with my own routine"

Looking at any changes in weaning and feeding with previous or older children and their younger children post involvement with the SAINW, some differences were definitely identified as being due to being involved with the weaning worker and were felt to be for the better.

"Yes there is quite a difference"

She was then asked further whether that was due to the SAINW or another reason, although the answer could seem a bit confusing, this is due to misunderstanding through language, the whole quote affirms the above statement.

“No it’s not because of the SAINW it’s just....before there was no SAINW and the Health Visitor was the one who told us and that’s what we did. But with this one it’s made quite a difference what the SAINW told us”

One of the mothers talked about how her eldest child wouldn’t eat family foods and had jars and packets whereas the younger one now did eat family foods. Another mum talked again about the importance of keeping to timed feeds. Some of this knowledge was also attributed to general experience.

“....I didn’t know anything about children and now slowly after my second child I have found out more things”

Looking also at any differences in family life due to the stated changes, life seemed to be easier one mum said mealtimes were less disturbed.

“I think family life was disturbed and I was upset that the children didn’t eat and now things are nice and they eat with a routine, they will calmly go to bed, it’s nice now before it was upset”

Whilst another mum talked about things improving generally:

“...So things are definitely improving and people are benefiting from it...”

One of the mothers talked about the encouragement she had received from SAINW to try more healthy foods and to eat alongside the child.

“you know make a fruit salad and eat that”

Although one mum stated that nothing in her own food had changed after meeting the SAINW, when probed further as to whether they were still eating the same things she clarified her answer with:

“Yes we still eat the same things but we have reduced the salt and chilli. You know we cut up a salad and we will peel a cucumber and give some to him and he will eat it if he wants or will just keep hold of it”

One of the groups mentioned eating more salad and fruit, when asked again about this it was confirmed:

“Yes we eat more now, we didn’t really eat it before, we only started after the SAINW came, the information leaflets that she gave us we looked at and read and now we have started to eat more, before we didn’t even buy five fruit and veg.....Sometimes after the evening meal we will make a fruit salad and the children...the whole family, me, my husband, we all eat it.”

Community Information

Towards the close of the discussions the groups were asked to think about the best ways of getting information about weaning and food and nutrition across to members of their own community, and if they were responsible for doing that how would they go about it. A few ideas emerged. Generally these were through meetings and clubs talking to people with more experience. Bilingual information would be required and also through Asian radio for mums that stay at home. Knowledge of Asian foods, being helpful and making it fun as the SAINW had done was felt to be important.

"In their own homes, if they don't know about the information properly, then go to their homes and tell them"

It was recognised that some families found it had to access the centres, possibly due to their children and that these are the people to visit at home, and one mother thought it was easier to understand information that is given in the home environment.

"...And you understand more, if you go to somebody's house I think you find out more, because then you can ask as well have you done that and what have you done"

One of the mums confirmed that she found it hard to go anywhere with a young baby but would welcome peer encouragement in her home or advice over the phone maybe from a friend with older children or with experience. Playgroups were also suggested as a venue where advice could be gained, where mums get together and discuss things such as feeding. New clubs were also suggested as a way to get information across.

"I think they should have more places where mums and children could go"

"...definitely sort of get people together and hold meetings and leaflets in different languages I think it would definitely help"

It was also recognised that the weaning worker (although local) had access to a car and could get out to do home visits.

Parents also discussed the value of a group they went to at Fartown Health Centre. The group showed parents how to make food for the babies and it was seen as a benefit to have somebody to show them rather than just reading information from books.

"they told us and it was in the books but we didn't understand and when we became mums for the first time they invited us and they tell/show and us right in front of you"

Moderator: *If you had got the same information on paper?*

"We wouldn't have understood" and "We would have left them, for the sake of having to read them"

Further discussion around whether a person (as opposed to leaflets or books) was preferred to get information over, prompted one mum to consider:

"No books are good if you have time but the Health Visitor and the Sure Start lady in my opinion are good"

She then went on to say:

“They are the best, better than books”

It was felt that knowledge of Asian food and culture helped particularly and one of the mothers talked about moving her child on through the weaning stage.

“After that when the baby starts eating our own food, they don’t know about that and then they send an Asian lady and she tells you in her own way and that is best also”

Asian radio was suggested as another way of getting information into peoples homes one of the mums suggested that particularly within some parts of the Asian community this would bring in information and knowledge from the outside world. Although she felt more could be done, things had moved on:

“...they need to sort of help the Asian community, they are doing a lot for the Asian community now as to back when, my mum had no help at all, you know she did what she thought was right”

Within one of the groups there was some discussion around a book given at birth (one to five years), which can be referred to at different stages but that there wasn’t always the time to read to get the information needed.

“...in my opinion the Health Visitor and the sure start lady coming to the house is best and you don’t get time to read a book, it just remains on the shelf, and only if the child troubles me a lot will I pick up the book to have a look at it...”

The practical approach was included in this discussion and how the SAINW promoted the fun and encouragement with the families involved: One example of this was a child’s progress through this process of charts and stickers, from refusing to drink any milk to asking for milk to drink.

“...so now he will drink his milk, and after that he will put his sticker on and say “I am the winner”

Summary

The mothers described the project as being valuable in addressing their needs, and talked about the changes in their thinking and actions after the SAINW intervention. They also appreciated the supplementary value of support around behaviour. The main barriers to implement change were their extended families who hindered efforts to follow the information given. The mothers identified that a SAINW would need skills such as life experience, bi lingual and befriending. It was important to them that the intervention was fun. Their suggestions on how to best deliver the service emphasised the importance of personal contact supported by literature, home visiting, via new and established groups. One mother suggested Asian radio as another method of getting information across within the community

Analysis of Interview with SAINW

A one to one interview was carried out looking at the experiences of the SAINW within the project. Exploring any areas of good practice, identifying any barriers encountered when delivering the project and to look at any concerns she may have had about delivering the intervention at the beginning or during the project. The discussion guide for this interview can be found in the appendix 5.

SAINW Role

The SAINW regarded the role within the project as that of support and advice around weaning methods and the types of food used to wean. The role is to support parents and to benefit the child. Support is delivered in the home following a referral or at various events, although not necessarily specific to weaning.

The role focused on the following issues:

- Food and nutrition
- The balance of good health
- Food labelling
- Anaemia
- Oral health
- Rickets
- Obesity

Strengths

The SAINW came into the role with experience of bringing up children, bilingual language skills and cultural knowledge along with experience from a previous position as a link worker/interpreter.

"I would say the majority that I've seen are Pakistani and Muslim and the different types of food as well you know that we use in our culture as well its just easy to talk about them...and they seem to feel more comfortable with me and I feel comfortable with them."

"I worked with Health Visitors and the midwives before, I was aware you know of the set up so it wasn't totally new to me, so I think I felt quite comfortable"

The experience of working whilst bringing up a family was seen as beneficial to the SAINW's time management skills.

Barriers and Challenges

The SAINW explained the main barriers to delivering this service were sourcing appropriate and good quality information in community languages and some of the group work.

Getting information in community languages was vital to support this role. A weaning leaflet had been designed with information supporting the project, including specific information for the Asian community, and was awaiting approval by the Professional Advisory Group. However, during the period of the SAINW being in post, this had not been completed and therefore was not available to use.

"That is a big barrier we definitely need something in community languages not just for English speaking"

The Department of Health produced useful weaning and nutrition leaflets, but Urdu/Punjabi versions were only available to be downloaded from the Internet affecting the quality. This was also a problem with other leaflets.

"I don't see why they can't have hard copies like they have in English, but no, they don't have it...and also not just the weaning leaflets the (inaudible) leaflets, just all the usual leaflets, if they just had them in the community languages it would be a big help."

Leaflets were particularly important to first time mothers.

"when I was doing the visits especially first time mums when you are talking to them about different type of food you should use and how you should cook it and things like that... I got asked quite a few times you know "have you got a recipe?", well I haven't really no, "

In order to overcome this obstacle the SAINW took on a research role to source information in community languages from areas with large Asian population including Bolton and Leicestershire.

"..they sent me a booklet which they use but said that they obviously couldn't let me have hundreds and hundreds. I actually photocopied those as well and they're in English & Urdu and that is more Asian type food as well and Asian type recipes."

Also, the process of identifying whether families need an interpreter does not always indicate what language is required and this could be seen as a potential obstacle.

Regarding group work, an initial barrier was the practicalities of running a large group; another difficulty identified was getting people to attend further groups. Ways of addressing these problems were identified.

"So I was speaking in English (this was for the benefit of colleagues that accompanied her) some of the ladies understood and some of the ladies didn't, so while I stopped and translated into Punjabi and whilst I was doing that the first group of ladies you know started talking, I found it really hard to get them back on track and it was the first one I'd done and I'd only been in post for like a few weeks and that really put me off"

"we said afterwards we learnt from that, I wasn't going to do a group that was that big"

Out of the three sessions (weaning groups) to which 15 people had been invited to each, attendances were of 5, 2 and 4 respectively. A barrier to recruiting parents was initially blamed on the process of sending out invitations, which was modified into an appointment letter. This seemed to increase the attendance due to the more 'official' type of approach. Poor attendance may have been due to the invitations being written in English, and because they were sent out to families whose babies were four months so families may question the relevance.

"even though the ladies we sent them out to were non English speaking ladies there would be somebody in the family who would read English. Whether they passed it on to them or if they did, whether they thought it was important enough to come"

"...and maybe they think oh my child's not going to be weaning yet its not relevant to me, I wont go, or maybe it could be that they've had older children you know....."

It should be pointed out that invitations were followed up with a telephone call checking it had been received but this was a time consuming exercise.

The timing of these groups was not seen as a barrier to attendance.

“Not morning time because people find it hard to get there... I did it at one, because if people have got older children that go to nursery and things, you know, then they can drop them off.”

The SAINW also indicated that with some group work it was more difficult to get messages across to all parents that attend when compared with individual home visits.

“With the group sessions some people take it and you know others don’t some not really bothered, you know we’re just going to a group and sat talking you know some people interested some people are not, you know the home visits they are generally interested in what you’ve got to say. That’s why they want to be involved.”

Support

When asked about the level of support received, the SAINW talked positively about the four-week induction. This included being shown the various venues that would be used, meeting key contacts, child protection, food and nutrition, breastfeeding and oral health as well as the essential training/induction package.

Following the initial induction the SAINW established a procedure for seeing families and this was closely supervised by a Health Visitor, including completing the first two or three visits.

“initially I felt a bit, a bit lost until I’d got all that and then when I started seeing the families, once I’d seen a couple of.. I sort of established myself in a routine you know, when I go see families this is what I need to talk about, I made myself a list, you know to make sure that I didn’t forget about all the things I had to discuss but once I’d done like a couple it was alright but the support was always there, Health Visitor was always there she said you know “anytime you come back, if you’ve done a visit and you come back and there’s a problem and you cant sort it I’m always there”

“...I didn’t feel as if oh I’ve got a problem and I don’t what to do and I don’t know what to ask, there was always somebody around”

Weekly sessions with the Health Visitor phased out when no longer necessary and the Nursery Nurse provided support with any behavioural issues identified. The SAINW had also been provided with appropriate literature to read.

When asked whether health and safety or training around home visiting had been included the SAINW said the confidentiality aspect of home visiting had been covered. As part of her induction into office procedures the safety aspect of home visiting was covered by the local system of using the ‘buddy’ book. This shows times and places where workers are, and if people are expected back. A mobile phone was not provided with the post, although she had used her personal one for work matters. The SAINW did not think that training around home visiting needed to be included as this was felt to be common sense and cultural knowledge was sufficient:

“..talked about confidentiality aspect. Obviously it was just common sense not training... I’ve never had any issues no, like I say its just common sense really. You go in.....you take

off your shoes, you ask do you want me to take my shoes off, some people do, some people don't, some people don't mind, and wait til' they ask you to sit down, try and be polite really"

To summarise, the SAINW felt that training had been sufficient for this role.

"I think there wasn't anything afterwards that I thought Oh I needed to know this and nobody told me... So I think it was. I would say so"

Operational / Practical Issues

Reasons for referrals were mainly around weaning but a small amount covered behaviour (nutrition/feeding related). The SAINW recognised that this had not been envisaged at the start and after some discussion, qualified her initial thoughts on the training and thought this aspect would be have been useful. A developmental approach was taken to assist this unexpected aspect of her role whereby the nursery nurse accompanied the SAINW during home visits to children with behavioural needs. Relevant literature accompanied this work.

Problems that presented were children refusing to eat, or a mother may say my child is not eating. The SAINW talked about how these problems were actually more about behaviour than nutrition, but felt that there was an indirect link and that it was more practical for her to deal with this as part of her intervention package.

"It is a behavioural thing, its not that the child is not eating or it's not as if Mums not aware of what to give. Mines like healthy eating, to make the family aware of what healthy eating is and the weaning methods and the weaning foods to use, that isn't, obviously it is linked because its all around food and nutrition, it is linked, but sort of indirectly"

These incidents represented only a small percentage of the referrals and hadn't diverted work away from nutritional information.

"...the most really we have are, not using the bottle, more than a pint of milk a day pureed foods when they're like you know 8,9,10,11 months, sweet foods, not savoury foods, lack of balanced diet, its mainly around that. Like a few cases where there was behavioural problems but like more older children... The child will eat, he'll eat but he just wont sit down to eat, so its just trying to get him into a routine, getting them around the table, turn the TV off, you know, toys, and everybody together as a family to eat around the table and make it a social thing. That sort of thing"

The SAINW felt that any initial concerns about the role were on a personal level, around managing the life/work balance. The amount of paperwork or duplication was described as a 'bug bear'.

"...more the paper, there's a lot of paper shuffling a lot of duplicating information that's sometimes a bit annoying... It's just like a bit of doubling up extra work really, not difficult it's like a bug bear really not difficult"

When asked about changes that could be made to the project, the SAINW talked again about the lack of appropriate leaflets. The problem was how would English leaflets be used by non-English reading Mothers and who would make sense of them?

“Oh gosh I’d definitely have the information, I think you need that beforehand, you know like the leaflets that you need in all the community languages. They are the basis of all the information I give out”

Although there was a positive aspect of being in the same office as the health team with regard to constant support, the down side to this was around logistics. The SAINW explained that due to the lack of space there was no desk, which meant sharing desks with other Health Visitors, and limited storage space. This resulted in taking work home, which became impractical as the project progressed and this was overcome by fitting an extra set of drawers and eventually a shelf space and a box for any notes/messages for her. Occasionally other offices had to be used elsewhere in the building.

“Yes when everybody’s there, quite claustrophobic and there’s no room to move that’s one of the things like there’s no space just to put things... But I think it’s an ideal place for me to be because there is the support there.....”

Also on reflection the SAINW talked about time and paperwork management. At one point in the project a sudden increase in referrals meant that Health Visitors were asked to stop referring for a period of time. The reason behind this was unclear but contributing to this was a two-week holiday period over Christmas. It wasn’t felt that the increase could be attributed to heightened awareness of the project.

“Initially it wasn’t that much, it started off slowly and then I got a lot at Christmas then afterwards caught up and then its been quite steady, not actually worked out how many visits per week”

The importance of building time into preparation for visits and writing up notes as well as preparing for events and groups all needed managing. The group sessions around weaning was an example of building in preparation time as different consistencies of food needed to be demonstrated.

“Yes and it all takes time. So it’s not just like Oh I’ve got a weaning session for an hour and that’s it. It’s like a couple of hours beforehand getting everything ready.”

As there had only been three weaning sessions, preparation had been done at home and although the SAINW was unclear how to claim any monies back.

“I actually do it at home and then bring it in, but you need to get all the fruit and vegetables together and all the spices and everything... Nursery Nurse says she uses whatever she’s got at home and I mean well you don’t always have everything at home do you, but then Julia says she’s got a code where you buy what you need and you go to Princess Royal and you get your money back... but my post is funded differently to hers, so I don’t know.”

The effect of not having a SAINW on the Health Visiting Team would be an increase in Food and Nutrition, and some behavioural referrals for the South Asian community, which the Nursery Nurse would have to take on. This would have a ‘knock on’ effect as the Nursery Nurse had helped with the Health Visitors to carry out assessments. Ideally, given the amount of notice, the SAINW could have passed the role on and cover would have been maintained.

“Yeah so now I’m leaving, then my work is going back on Nursery Nurse and then she wont do much assessments and that is going to go back on the Health Visitors and then they are going to be back where they started as well”

Finally, the SAINW talked about a presentation that was required for SAHLP (part funders of the project) before the end of the project. There was a suggestion that the presentation could be used as part of a discussion around a similar role in another area. Attendees of the meeting were happy with it and seemed impressed that initial targets had all been met.

Summary

The analysis of the SAINW interview indicates that the objectives of the project were understood and that there seemed to be more success working with parents in the home rather than in groups. The support received had been adequate for this role and the main barriers to delivering the service had been not having the appropriate materials in the community languages.

Analysis of Focus groups with Health Teams

The two Health Visiting Teams that worked with the SAINW were both based at Fartown in neighbouring buildings. Included in these teams are Health Visitors, Community Nursery Nurses and Health Care Assistants/Clerical. The teams differed in that one works in a geographical area and the other attached to a General Practice. The two Health Visiting Teams work with different caseloads, one being geographical and the other GP based. The geographical caseload (attached to 20 single handed GP's) held the majority of first generation south Asian families due to these families gravitating towards south Asian speaking GPs. At the time of the evaluation the caseload profiles were starting to change and an increase of non English speaking patients were registering with the practice based team.

To accommodate work commitments and to enable full discussion about the project two focus groups were held. The issues addressed included background to project, value of the role, caseload management, barriers to success, support need, the use of 'unqualified staff', and a discussion about whether the project was a success. The discussion guide for these groups can be found in the appendix 6.

Project Background

Health Visitors explained the background of the project was to address specific needs related to nutrition problems identified within South Asian Families with English as a second language. Health data, caseload information and anecdotal evidence were used to identify the need for a Weaning Worker that could deliver a culturally sensitive service.

"lots of nutritional problems related to poor diet, poor oral health..."

"...so there's an awful lot of children who will have iron deficiency that aren't picked up, you know you have to be quite severe for the paediatrician to be referred to the paediatrician and for them to do the tests"

"It came out of a brief profile that we did on the caseload and it showed that we did have problems with nutrition particularly during the weaning period"

"we know through research that's been done in lots of areas, that we have high levels of iron deficiency, we've got high levels of dental decay and like ___ was saying, cases of rickets."

"there's oral health evidence from the dental people that there is twice as much decay in the area"

One of the Health Visitor's had heard of a similar project at a Health Visitor forum,

"some of the Health Visitors trained up a link worker, so they got someone speaking Urdu/Punjabi from the same culture who was a lot more effective than a Health Visitor spending 20 minutes as a one off talking about nutrition with families."

Listed below are the nutrition related aspects both groups identified:

Anaemia/Iron deficiency
Oral Health
Reliance on cows milk

Failure to thrive
Using a lot of sugar
Nutrition deficiency
Lack of five a day
Oral health
Use of sugar, honey & lucozade
Not on solid food (at appropriate age)
Missing important feeding milestones
a lot of sweet food instead of fruit & vegetables & meat

Families get involved in the project if they are having problems around nutrition and this can be identified by Health Visitors either at the 7-8 month check, the health clinic, or at any other contacts.

“When they’ve got problems really”, “they should have been on family foods and they’ve not moved on”

“we talked to the families, would they like the opportunity to work with someone and if they agreed then we would do a referral form”

“... we visit all families around 3 months and if families need extra support....”

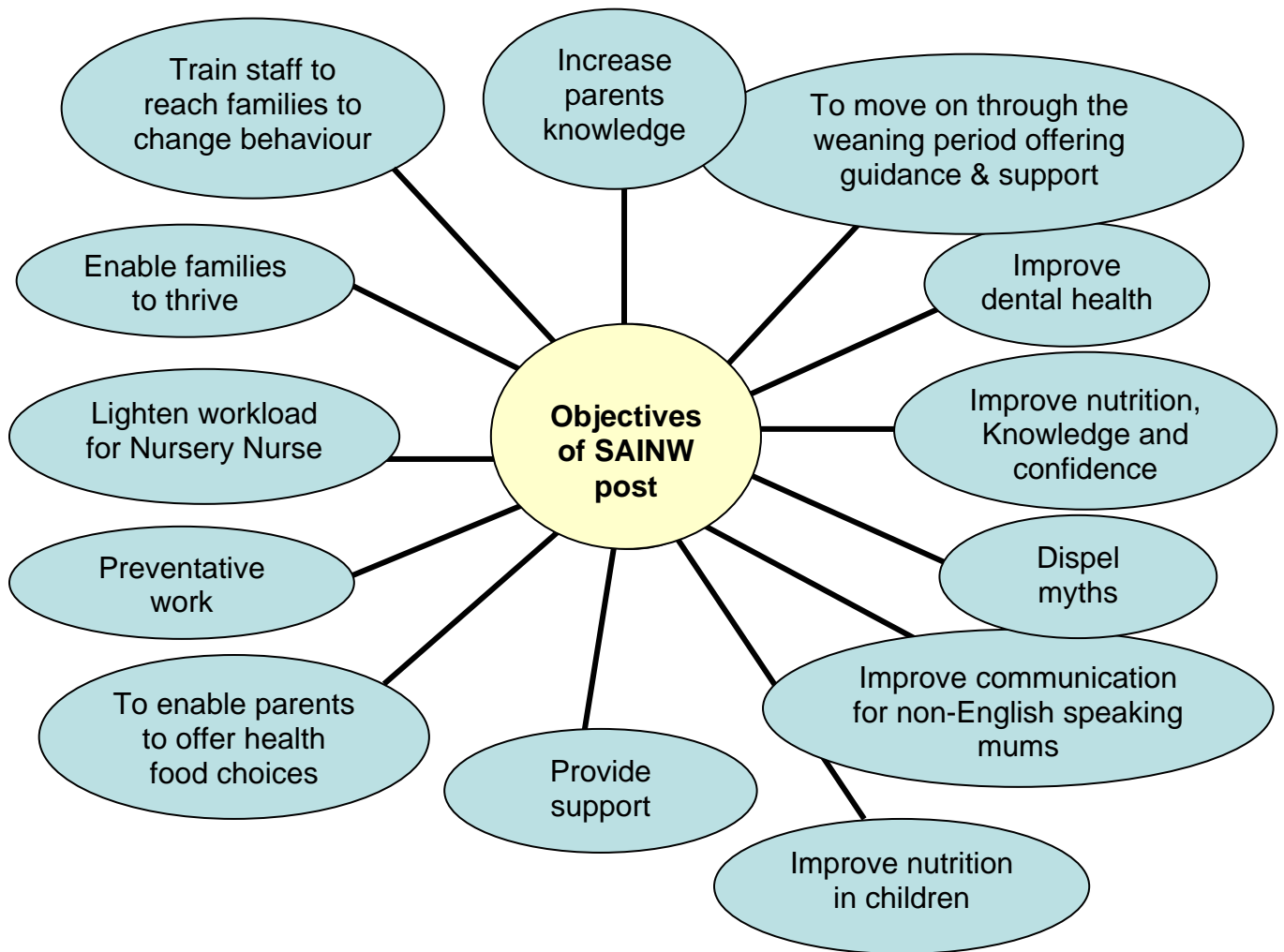
One of the aspects of the SAINW role within the project was to hold weaning groups; these are targeted invites to families with young babies.

“... when we invite them, coming up to the age for weaning, to a group to chat about healthy options really”

Health Visitors generally found the referral process easy to complete although one Health Visitor found it too lengthy. This duplication was explained as necessary for ease of record keeping and evaluation. The referral process had changed slightly at the beginning of the project.

“But we also followed it up with a conversation quite often because the SAINW was part of our team”

The objectives of the project stated by Health Visitor teams can be seen in the spider diagram below:



Value of SAINW

Delivering a culturally sensitive service was seen as a benefit to the team, both for families receiving weaning advice and the advice that the team received for all areas of their work. One Health Visitor spoke particularly about understanding lifestyle, tradition and different ways of life and recognising how families who have just moved into the country and have no English may not act on information or advice given by someone they may not relate to at that stage.

“so its using a better way of doing that, a more appropriate way of showing new and healthy ways of doing things for children”

“I think for the families. For her to do it with the Asian ladies, I feel it is probably better coming from her than from me, that they might think ‘what does she know about our culture’ ”

“the quality of the communication, the intonation, colloquial language, everything, when you are trying to communicate with people it’s far easier to speak to someone using the same language”.

“...because she is from that culture and she can identify with them and more importantly parents can identify with her so I would say that’s the highest value”

Having a dedicated nutrition worker also relieved the team’s workload.

“if you had a family with quite complex problems she could just work on that one, that specific thing”

The SAINW made the team more efficient and improved the quality of the service. A Health Visitor described an example of this:

“She didn’t have to do what we have to do which is always book a link worker”, “you’ve got to meet up with a link worker, you’ve got to meet up with the link worker at the right time at the house and if you’re late or they’re late, you know there’s all these ongoing things, complexities... And then when you are at a visit you can’t book your link worker for next time so you have to leave it with the family that you’ll get in touch with them and then you come back to the office, book another link worker and send out an appointment”

“I think there is a definite difference in quality, an improved quality when you are talking to someone in their own language than when you are speaking through a third person”

There were also benefits to families in the way the service was delivered as the SAINW could offer telephone support to families and only 1 member of staff rather than 2 undertook visits.

“If you’ve done a lot of work with someone you can just ring them in a couple of weeks... We can’t do that we’ve got to get someone else to do it for us, or go out with the link worker and do it”

“she could communicate with people on a one to one basis, which I think would seem less intimidating for families, you know with one person going in.”

An extra added value was the general cultural information dimension added to the team in having a reference point and check and balance to hand.

“having her there to just check things out you know when things have been said, or situations that have happened within the home, certainly when I’ve not understood I’ve come back and asked what’s that about?, why did that happen or what’s likely to?”

Caseload Management

Having a SAINW as part of the Health Visiting Team had an effect on caseload management due to the workload being reduced. At the time of these discussions the post was vacant and gave a unique opportunity to view the effect that had on the teams, in that they were able to consider before, during and after, at this point.

“ I used to do a lot of nutritional visits that I would have taken up, obviously when the SAINW came that relieved me of doing all of that work, I was then able to perhaps look at other things. Perhaps you know I would have a waiting list so I was able to reduce that time, referrals from Health Visitors I was able to do more promptly rather than think they’ve got to wait six weeks before I can look at that. And then move on to like 2 year 3½ year assessments. Since the SAINW has not been here it has basically gone back to nutrition, nutrition, nutrition”

“You only have to look at the referrals the SAINW had, amount of time being spent on each of those, and work out that would have been added to nursery nurse and our caseload, we would have to absorb that, which again then has a knock on effect on assessments and that you leave, well, you leave those.”

The GP practice based team had far fewer non English speaking south Asian families but did recognise that this situation was changing quite rapidly due to the practice now having Doctors who speak Urdu/Punjab and an increase of first generation families both moving into the area and changing GP's.

“Well in our current caseload, not a huge impact on me at the moment, but saying that our caseload is changing quite rapidly”

“Because we are having more Asian doctors so more clients are coming to us who speak English as a second language, so we will be needing more of it in the future yes”

One view of the post being currently vacant was:

“Just that since she's gone its caused a lot of problems next door mainly, because the nursery nurse is having to do all this work again, and I've found two or three families that I know could really do with that extra support that I haven't been able to do”

Barriers to setting up the project

The length of time it takes to set up the project and financial constraints were seen as barriers to setting up the project. Also that this post had to be set up from scratch, there was no 'template' or similar post to base it on.

“Well I mean it takes a lot of time to write up a project doesn't and we had no framework or anything in this area...”

“the finance around it, how you would start it up, the basic stuff that you need to do before you can get a project up and running”

Although a bank Health Visitor was employed to free up time to plan the project due to various circumstances the cover wasn't sufficient and sometimes increased the workload. The envisaged support time therefore for the development of the SAINW role was in reality significantly reduced.

Support

The SAINW received standard preceptorship and supervision, and completed an induction period covering various modules; all this seemed to work well. There was oral health training, but the additional food and nutrition training (four days) that was completed is currently unavailable due to lack of funding.

“She had what we call a preceptorship period up to six months so she had that ongoing support where she could come back to me with any concerns..... Initially we had to spend a bit of time, but then it trailed off because was, just got on with it basically, maybe with somebody else it may take a little bit longer, each individual..... It's part of what we do, we look at people development as they're going on anyway, (we) didn't have to do anything out of the ordinary.”

The type of support given differed:

“...I would say you could count in like 10’s of hours up to 100 hours, not supporting afterwards but getting the bid, going to meetings, writing the job description, interviewing, getting the references...”

When asked if supporting the SAINW role affected client contact time, the feeling was about the general positive effect and that supporting this individual had not had a detrimental affect on their client contact time. Health Visitors explained that there was a positive effect as the SAINW took on more families to give specific weaning support.

“she was taking on more of the clients that you might have been visiting, or nursery nurse might have been visiting for that specific thing.”

Another aspect of the support element was about ensuring the same advice and support went out from the whole team.

“And like I say it’s this drip, drip thing that you keep giving the same information, and you know we were giving all the same information as she was...”

Also recognising when the SAINW needed direction in a particular area, for example there were families who the SAINW had difficulty with. This was seen as part of the role, in that you can’t help every family.

“Yes I think she found some families as we all do, extremely challenging and you know the change wasn’t happening, but that’s part of our job anyway, you can only go with people as far as they want to go”

“I think some families she just had to accept, you know she was quite keen to keep going and sometimes, and once or twice I said on my, on the referral forms she sent back, I think we’ll leave it at this now.....”

There were however, problems with some of the additional work the SAINW was expected to carry out as part of the contract. This included presentations and completing forms/questionnaires unrelated to the food and nutrition work, with other members of the family being visited.

“it was written into her contract that she had to do so many presentations and things for SAHLP... they encroached into her time because she had so many referrals from us to do the weaning stuff and then she was having added pressure on from them... quite often they were requested at short notice, which again was not acceptable really.”

“She had to fill these questionnaires in... once you open that can of worms; actually start asking someone about their health, then a lot of stuff came out.”

The Health Visiting Team overcame this problem by talking to SAHLP. It was agreed that this aspect of the role should cease.

The Use of ‘Unqualified Staff’

There was mixed opinions regarding the use of unqualified (i.e. non health background) staff in the SAINW role. Health Visitors felt it was useful for the worker to have some experience and they talked about the individual’s attributes and educational background being important to the success in this role. These were:

"I suppose it's down to the training she's going to get in post really, and how she is able to take on board that training, and it depends when you say unqualified how unqualified?, level of understanding..... in case she is well educated, the training courses she went on she did extremely well, she picked things up very quickly, she was very astute wasn't she, she was very committed and good at what she did... She looked more broadly, she didn't have tunnel vision, which comes with education; you can look more broadly and think more deeply about what's going on and not take so much at face value."

At a more strategic level, it was recognised that there could be problems in recruiting staff that from a non Health Visiting background.

"I think it can have its problems, I think people can have ideas that are based on myths and tradition rather than on evidence, I think the person needs a lot of training, needs the right attitude and approach, because you know working with groups you need group work experience, engaging people in the communities.."

Were the objectives met?

When asked to think about the extent to which objectives of the project had been met, all Health Visitors felt that the service was being delivered in a culturally sensitive way.

"all the cultural issues, so, complex stuff, it hasn't been a simplistic role at all, going in saying 'give your child this, that and the other'. Huge amounts you have to consider."

"....she (the SAINW) did an evaluation, it was behaviour change, the vast majority showed partial or full behaviour change and only two or three didn't. So to me then that achieved the objectives"

"Yes and I suppose that's one of the biggest things on there (the list of objectives) really that.... the obvious that we have all been talking about, providing culturally sensitive information"

The reduced workload of having a specific member of staff for weaning work also helped Health Visitors manage their workload and that there was an added benefit in giving support to other areas of their work.

"working with in that role decreased the stress of a lot of visits, you know, a lot of demands on us, and nutrition's a huge, we know that nutrition is a huge issue. The knock on behavioural side of it as well, because it not just straightforward 'your child must eat this that and the other', it's all the behaviour around eating that causes problems."

Referrals had also increased and the target for numbers of families worked with had been met.

"....did a report at the end I think she saw 30 to 40 individual families which is what her target was,..."

Health Visitors then added that a key to the success of the project was continuation and the impact it had on the extended families, which they were unsure that it had done.

"it may be that there are some successes but there are just as many that need continual advice, because we quite often find it's the drip, drip, drip effect."

“it may be that information is given to an extended family and that might be passed onto other family members.”, “I think that’s a good point, quite often because particularly grandparents, grandmothers would be there and quite often they are key as well.”, and “it’s working with that generation rather than the actual mother, that’s the difficult bit isn’t it and the key to moving things along.”

These interviews were carried out when the SAINW post was vacant this enabled the Health Visiting Teams to reflect on the current situation.

Summary

The Health Visiting Team felt that the SAINW project was successful in delivering a culturally sensitive service addressing the local needs. They valued the improved quality and efficiency that having a specialised nutrition worker brought both to the families and the Health Team Workload.

Key Findings

The following key findings are drawn out of the analysis of quantitative and qualitative data and have been triangulated. The findings are under headings of common themes that arose.

Objectives of Project

The objective as outlined in the proposal was to develop a weaning intervention that is culturally appropriate and effective in enabling parents of south Asian origin to establish healthy weaning patterns.

The objectives that were identified by the SAINW reflected those in the original proposal, as did the Health Visiting Teams, however they added further objectives related to operational issues. Examples of these include lightening the workload within the team. The Health Visiting Teams addressed the point of whether these objectives had been met they felt that the delivery had been culturally sensitive and the target number of families had been seen also that their workload had been impacted on.

Value of Project

The value of the project/role was viewed positively benefiting both the families and the Health Teams with improvements in communication, quality, information and efficiency. The mothers who took part in the focus groups talked about the value of the project in terms of addressing their needs and problems. They also cited the additional values of support around behaviour and gaining knowledge of cheaper and healthier food. The monitoring data showed that the referral reasons reflected the original aims of the project. The positive outcomes recorded with the majority of the families reaffirm the projects worth.

Induction, Training and Support

The general feeling was that this had worked well, to some extent this could be attributed to the individual. When considering experience or background for this role there were some differing views as to whether a non-health background could be detrimental, importance was attached to education, ability to access information along with life experience and common sense. Although the training/induction was felt to be comprehensive, the inclusion of an element around children's behaviour would have been beneficial. The ongoing support element is part of the Health Visitors role but crucial to the SAINW.

Referral Process

The Health Visitors completed an initial referral with levels of priority, reasons for referral (numbered), and additional notes. This form developed over time. A discussion between the Health Visitor and the SAINW accompanied each referral. The SAINW completed contact and outcome sheets, which were available for monitoring. There was duplication of information and an increase in paperwork some of which the staff viewed as necessary.

Barriers, Challenges and Concerns

At the outset there were the usual challenges faced in setting up a project and lack of the expected backfill support, in time these were overcome.

Delivering the interventions the SAINW talked about the lack of appropriate resources, good quality information in community languages, office space, group attendance, interpreter information. The challenge of getting people to groups was considered and

although partly addressed could not be seen as being completely resolved. The other identified resource barriers are still unresolved.

The mothers talked about members of their extended families hindering their efforts to follow the information given, this is interesting in that the Health Visitors concurred with this and identified that any behaviour change needed to include the extended families. It was a recognised challenge within the project around some family's resistance to change. Both these aspects are viewed as ongoing challenges.

Changes to Project

Regarding any changes or redesign of the project the mothers reinforced key aspects of the role. They identified skills the person would need to have including, life experience, a bi lingual befriender who makes the intervention fun. When the mothers looked at how best to deliver the service the emphasis was on personal contact supported by literature, home visiting, new and established groups, and utilising Asian radio. The most important change identified by the SAINW was to have the information that underpins the role available at the beginning of the project.

Outcomes and Changes

When looking at the monitoring information at the time of the evaluation there were 31 positive outcomes from the 45 referrals.

The mothers talked about the changes in their thinking and actions after the SAINW intervention. These were positive changes around confidence, knowledge and the application within the family.

The health teams felt the objectives of the project were being met; they were able to view their changing workload with the emphasis on nutrition issues. They highlighted the need for the continuation of the project citing that constantly reinforcing information, delivering that information in a culturally sensitive way and ensuring consistency of information would contribute to bringing about change.

Conclusion

The SAINW project was set up with the overall aim of developing a weaning intervention that is culturally appropriate and effective in enabling parents of South Asian origin to establish healthy weaning patterns. Extensive literature relating to the inadequacy of the weaning diet in some British Pakistani and Bangladeshi families suggests that weaning advice and support offered by routine Health Visitor contact to families is often ineffective.

There are limitations in the subjective nature of the method used; findings show how these particular groups perceive this intervention.

Initial findings of the evaluation indicate that this approach has been successful in addressing the original aims of the project. For example, the positive outcomes of the referral to the SAINW for families with a lack of a balanced diet are linked to a lower risk of anaemia, dental health, and obesity. The findings also indicate that the referral reasons reflect local health concerns.

The project was effective in providing a culturally sensitive service with improved quality, efficiency, and capacity for intensive interventions.

Further work needs to be done to investigate cost effectiveness, however, the reduction in the use of interpreters along with telephone support replacing some home visits are potential cost savings which may partly offset the cost of the SAINW. In the long term this may lead to savings in diet related illness, which require more expensive treatments, for example referrals to paediatricians, dieticians and treatment of dental decay.

Monitoring information based on the perception of the SAINW and Health teams indicate that the original objectives were met. They valued the project as it relieved the nutritional workload and was culturally sensitive, bringing an added dimension to the Health team. Although there were small numbers of parents that took part in the focus groups, they were clear about the positive benefits of the project.

The common barrier identified by the Health teams and parents, was the influence of extended families and the recognition of this when considering changes in behaviour. The SAINW indicated lack of appropriate information and low group attendances as ongoing barriers.

During the evaluation home visits were seen as more effective, reasons for this include an identified need and the consent from parents to be referred to the project. Potential group attendees were targeted by age of child rather than any identified problems, therefore the necessity or appropriateness may have been questioned. The mothers, when describing how they would deliver this intervention to their own community, confirmed the value of receiving information and guidance in the home.

Recommendations

This report helps to emphasise the importance of continuing to consult with service users and providers when planning to develop activities and services.

When considering the importance that has been attached to the constant delivery of messages to influence behaviour change, the recommendation is for the information and support to continue to be delivered in an effective and culturally sensitive format that the target audience can relate to and encourage them to question their own practices.

There needs to be sufficient support and resources in place for the SAINW. This includes training around children's behaviour during the SAINW's induction period, and having information in community languages.

Further work needs to be done to establish the future impact the project may have on the identified nutritional issues on the target population and how to continue this service. A recommendation is to make sure staff are aware of any potential anomalies or pitfalls on the paperwork where mistakes could occur.

Referral to SAINW sheet

One form for each child in family as needed.

One copy in child health notes, one copy in SAINW referrals folder

Child name.....

DOB.....

Address.....
.....
.....

Postcode.....

Telephone number.....

Ethnic origin Indian/ Pakistani/Other -please state.....

Language spoken with SAINW

Other information of relevance (visit in pairs/ domestic violence/ special needs, child protection concerns etc).....
.....
.....

Referring Health Visitor.....

Base.....

Contact number.....

Date referred.....

Reason for referral (please indicate all that apply for this child in the 'reason for referral tables one and two' over page and add further details below

-Please indicate priority of each problem from 1 to 5 (5 being urgent) on the tables

.....
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.....
.....
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.....
.....
.....

SAINW monthly contacts monitoring sheet

SAINW will write all contacts in diary; name, address, of children in family needing support and collate these figures each month on this sheet

South Asian Infant Nutrition Worker (SAINW) monthly monitoring sheet

Month 2005	Number of families seen/attending	Number of children in families receiving direct advice
Number of families receiving one to one home contacts		
Number of families attending one to one clinic contacts		
Number of families receiving opportunistic one to one contacts		
Number of families receiving one to one telephone support and advice		
Number of families attending group sessions		
TOTAL numbers of families accessing service this month		
Any training session given by SAINW (state subject, dates, number and job description of attendees)		

Agreed family plan

Date seen	Home (H) Group (G)	Problem number	Intervention by SAINW TO INCLUDE: i. Raise awareness of links of current behaviour with child health problems ii. Give appropriate health messages	Agreed action plan with family	Progress TO INCLUDE: i. Evidence of changes in behaviour ii. Evidence of family's raised awareness of problems associated with initial behaviour	Date of next contact (minimum of 3 to be offered)

Discussion Guide Weaning Worker Project

1. Introduction (3 mins)

Thank you for coming along to the focus group. My name isand this is and we are here as an independent person to gain your views on feeding young children and babies.

Before we get going, I'll run through a few things you need to know....

- If the fire alarm sounds, the evacuation route is.....
- The focus group will last for around 90 minutes. Is everyone okay to take part for the full duration of the group?
- Our discussion today is totally confidential. We will be using a tape recorder to record and transcribe, but it will not be linked to any individual and no one will be identifiable in the final report.

Is this ok?

Please feel free to be totally honest and express your true opinions

The focus group will be conducted within the Market Research Society of Code of Conduct.

- For courtesy, there should only be one person talking at any one time. If more than one-person talks at once it is very difficult to note what everyone is saying.

2. Ice breaker (5 mins)

To get started, could everyone introduce themselves and their family?

(do seating map and record names)

3. Positives and negatives about being a parent

Thinking about your role as a parent, in two groups please can you write down 3 positives & 3 negative things about being a parent? I'll give you a couple of minutes to think.

Each group to feedback – write on flipchart

Verbally summarise positives & negatives – check are happy with summary

4. Current Knowledge (10 mins)

Activity

From your current knowledge please list all the things you believe are healthy and all the things that are unhealthy for children.

(Split in groups of 3/4 and ask them to write on the A4 sheet provided healthy & unhealthy)

Probe: *Food and Drink*

Why Healthy and Unhealthy

Feedback from groups and write on flip chart

Verbally summarise healthy and unhealthy things – check everyone is happy with summary

5. Understanding Stages

Can we take some time to talk about food/(feeding)

How do you know when to try food as well as having milk?

Probe: *What age would you start giving children solid food?*

What types of food

What type of milk

What information do you think is needed when weaning a child?

Probe: *How do you get information on what age and what foods?*

6. Next stages

Lets talk about moving on from introducing solid foods

What is the next stage?

How important is milk in the diet after 4,6,8,12 months?

What is milk being replaced with?

How many meals?

How many of you make special meals for the child?

Probe *what sort*

Why

Do your children like ordinary family foods?

Where do children tend to eat their food?

Probe *whom do they sit with (eat with adults, eat at table or on own)*

What times

What advice or support have you had with feeding your baby?

Probe: *clarify sources*

Where did the information come from? **(WRITE UP ON FLIPCHART)**

Probe: *for example, television, leaflets, health professionals, family*

Are there any other sources of information about feeding children and babies that you are aware of?

Summarise and feedback all the sources of information

7 Value of project

Following on from the previous point, what did the SAINW come to help you do?
(Verbally summarise and feedback)

What information did you receive from the SAINW?
(Verbally summarise and feedback)

Did any of the information surprise you?
Probe: If yes, what and why?
(Verbally summarise and feedback)

How useful did you find the information?
(Verbally summarise and feedback)

How useful did you find having a person to help you?
Probe: *Why was this*
(Verbally summarise and feedback)

How realistic / achievable do you think the information/advice was?
(Verbally summarise and feedback)

Apart from parents are there any other people who you think need to have access to this information?
Probe: *other family members, playgroup, nursery*
(Verbally summarise and feedback)

8 Changes in Weaning

I would now like to talk about any changes that have occurred since you have been in contact with the SAINW

Have you changed anything about how you feed your children?
Probe: *If yes what have these changes been? (when/times/who eat with)*

How do you feed your youngest child compared to any older children?

What difference do you think these changes will make to your family life and youngest child?

Has being in contact with the SAINW changed the way you think about feeding children?

So if we can summarise any actual changes in what you do about feeding your child/children
Any changes in the way you think about feeding babies and children

9 Closing exercise

Thinking about weaning and food and nutrition, if it was your job to give information and support to new mothers in your community, how would you do it?

10 Close group (3 mins)

We would like to thank you all for coming and taking part in the group. The information you have given has been very interesting and useful.
Give out incentives and ask them to sign names

Interview with South Asian Infant Nutrition Worker SAINW

Aims

To explore any areas of good practice identified during the project

Identify any barriers encountered in delivering the project

To explore any concerns about delivering the intervention at the outset or during the project

Guide

Please explain your role

Please explain your background and how that equipped you to do this role

Any key skills

What did you find easy about the project?

What did you find difficult about the project?

Was there any barriers/obstacles to you working on the project?

If so how did you overcome them?

Were there any barriers that you couldn't overcome?

Did you feel as if you had enough support in this role?

Did you have training for the role?

What was the training?

Was it sufficient?

Did you find the referrals were right for your abilities?

Did you have any concerns about the project at all at the outset?

Did you have any concerns about the project whilst you were doing it?

What would you change about the project if you were starting it all again?

DISCUSSION GUIDE FOR SAINW – HEALTH TEAM

INTRODUCTION

First of all could you talk about what you see as the background for creating this role
(*historically, knowledge of area & clients-were there any barriers?*)

- Why do parents get involved in the project
(*how, what's the process, how do they feel about the referral process*)
- What do you think the objectives of the project are
(*write on flipchart*)
- What do you see as the values of the SAINW role?
(*culture, religion, sensitivity, engagement, empathy*)
- What are your views on using an 'unqualified' worker for this role
(*i.e. non hv background, preconceptions etc*)

SUPPORT AND SUPERVISION

- What support did you give to the SAINW Role, initially and ongoing
(*inform, support, mentor, training, induction*)
(*look at time needed for this support-impact?*)
- Did supporting this role effect client contact time, initially and ongoing
(*how did they feel about this*)
- Did you encounter any barriers or challenges in your supportive role
(*time, first time in supervisory/support role*)

CASELOAD MANAGEMENT

- What if any effect has the SAINW role had on your caseload management
(*Sharing out the work, more or less, quality*)
- Thinking about your contractual obligations, has this role effected them in any way
(*Specific to what you 'have' to do, more or less, quality*)
- Looking at the objectives, on a level of 1 to 10, where would you put each of the objectives?